PIONEER®
YOUR INSURANCE

SafeTRIP
Comprehensive Travel Insurance

TRAVEL CLAIM FORM

Emergency Hotlines: +632 8817 2021 ▪ +632 8396 9885 ▪ +65 3129 2880 (WhatsApp)

IMPORTANT INSTRUCTIONS:

1. For claims processing, this form and all necessary documents have to be submitted within sixty (60) days after the date of incident. The company reserves the right to request additional documents as deemed necessary.
2. Submission of required documents does not guarantee approval of your claim. The submitted documents will be reviewed and evaluated, subject to limits, terms and conditions of your existing Travel Insurance Policy.
3. Failure to submit the required claim documents within the prescribed period may be grounds for denial of the claim.
4. Basic requirements should also be submitted: 1) copy of airline tickets and/or boarding pass 2) copy of passport (international travel) and any valid Government ID (local travel)
5. For claims related to Medical (in-patient & out-patient) and Emergency Assistance Benefits (e.g. emergency medical evacuation, repatriation of mortal remains), the Attending Physician Statement must be filled out, signed by the Attending Physician and submitted to Pioneer for claims processing.

GENERAL INFORMATION

Policy No.:	Insured Name:
Date of Birth:	Occupation:
Home Address:	
Contact No.:	Email Address:
Are there any other insurance policies in force covering you in respect of this travel? ☐ Yes ☐ No If Yes, please provide details.	

MEDICAL TREATMENT/PERSONAL ACCIDENT

State the nature of your illness or injury.
Have you suffered a similar condition or a recurrence of a previous illness or injury? ☐ Yes ☐ No If Yes, please provide details.
State the net amount being claimed.
Give the name(s) and address(es) of your usual attending physician(s).
If hospitalized, give name and address of hospital.
Hospital confinement: From (dd/mm/yyyy) _____ at _____ AM/PM to (dd/mm/yyyy) _____ at _____ AM/PM

EMERGENCY TRIP CANCELLATION/TERMINATION

When was the trip booked?
When was the trip cancelled?
Reason for trip cancellation/termination:
Amount being claimed due to trip cancellation/termination:

FLIGHT DELAY/MISSED CONNECTING FLIGHT

ORIGINAL FLIGHT DETAILS	ACTUAL FLIGHT DETAILS
Date (mm/dd/yyyy):	Date (mm/dd/yyyy):
Departure date (am/pm):	Departure date (am/pm):
Place of departure:	Place of departure:
Airline & flight no.:	Airline & flight no.:
Reason for flight delay/missed connecting flight:	

BAGGAGE DELAY

FLIGHT DETAILS	COLLECTION OF DELAYED BAGGAGE
Date (mm/dd/yyyy):	Date (mm/dd/yyyy):
Departure date (am/pm):	Time (am/pm):
Airline & flight no.:	Place:

LOSS OR DAMAGE TO BAGGAGE

Which police authorities were advised?

Please attach Police Report related to the incident.

Name of airline & reference number:

Give details of items/amount to be claimed.

ITEMS	DATE PURCHASED	PLACE PURCHASED	DESCRIPTION	AMOUNT BEING CLAIMED

LOSS OR DAMAGE TO GOLF EQUIPMENT/LOSS OF HAND CARRIED PERSONAL GADGET

Which police authorities were advised?

Please attach Police Report related to the incident.

Give details of items/amount to be claimed.

ITEMS	DATE PURCHASED	PLACE PURCHASED	DESCRIPTION	AMOUNT BEING CLAIMED

LOSS OF TRAVEL DOCUMENTS

Which police authorities were advised

Please attach Police Report related to the incident.

OTHER BENEFITS (e.g. Flight Diversion, Missed Departure)

Please give a short description of the circumstances giving rise to your claim.

BENEFIT BEING CLAIMED:	DETAILS:

CLAIM PAYMENT DETAILS

☐ **DIRECT CREDIT TO MY NOMINATED BANK ACCOUNT**

Name of Bank: ☐ Banco De Oro ☐ Metrobank ☐ BPI Bank Branch: _____

Bank Address: _____

Account Name: _____ Account Number: _____

Relationship to the Insured (if bank account is other than the Insured's): _____

NOTES:
1. Whenever applicable, cost of direct crediting will be deducted from the approved claim amount.
2. If bank account is other than the Insured's, two valid ID's (photo-bearing, government-issued) of the owner of the bank account is required.

☐ **CHECK**

Name as it should appear on check: _____

Relationship to the Insured (if bank account is other than the Principal Insured's): _____

NOTES:
1. Any changes from the mode of payment or change in the content of the check will be for the account of the Insured and will be deducted from the proceeds.
2. Check becomes the default option if preferred mode of payment is left blank.
3. In all payments, payee should be of legal age (18 years old and above). For payee other than the insured, acceptable relationships are as follows:
   - Employer-employee
   - Immediate family member (parents, spouse, children of legal age)
4. Claims Payment Details are still subject to Pioneer's validation

AUTHORIZATION, RELEASE AND DECLARATION STATEMENTS

NOTE: Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim.

I/We hereby certify that to the best of my knowledge this claim form does not contain any false, misleading or incomplete information. I / We understand and accept that in the event that this claim is found to be fraudulent in whole or in part, the Policy shall be void and all the rights to recover thereunder in respect of past or future claims shall be forfeited.

I/We hereby authorize PIONEER INSURANCE & SURETY CORPORATION and/or its duly authorized representatives to collect, retrieve, use and/or otherwise process from any government or private hospitals, offices or any other personal information, controllers and processors who collect, hold, process or use any of my and the named insured's personal information, and for any of the latter to furnish Pioneer Insurance & Surety Corporation Insurance Inc. and/or its duly authorized representatives with, any personal information, sensitive personal information and privileged information, including copies (original or certified) of documents, relating to any of my and the named insured's personal information. This authorization is being made in connection with any claim on the insurance policy or policies issued by the insurance company on the life of the abovementioned insured. It is understood that any action of any medical practitioner, medically related facility, insurance company, government agency or instrumentality or any other personal information controller and processor who collects, holds, processes or uses any of my personal information may take in connection with this authorization releases said persons or entities or any and all members of their staff from any responsibility or obligation in connection with the release or processing of such records or information.

Any payment made by Pioneer or any payment received by me shall constitute as full, final and complete settlement of this claim. I further agree that the Company is subrogated to my rights of recovery on all claims and rights of action to the extent of the payments made and/or on account of the losses incurred or which may be incurred by the Company against any person, corporation or entity in connection with this claim and I further agree to authorize the Company to commence all legal actions and proceedings necessary to enforce my claim or recovery thereof with any undertaking to extend my cooperation or assistance whenever necessary.

I/We hereby certify that I/We have carefully read and clearly understood the terms of the above said authorization, and do hereby voluntarily accept and acknowledge the same as an informed expression of my own free will.

DATE	**INSURED (Signature over Printed Name)**

FAILURE TO COMPLETE THIS FORM MAY DELAY PROCESSING/PAYMENT OF YOUR CLAIM.

PIONEER INSURANCE & SURETY CORPORATION
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