TIC
TRAVEL INSURANCE CONSULTANTS
Travel Assured

CLAIM FORM

Please complete ALL fields. Take note of the Supporting Documentation required on the Check List.

1. PERSONAL DETAILS

Claimant details

Title: _____ Contact number: _____
First name: _____ Email address: _____
Surname: _____ Date of birth: _____
Current Address: _____ ID/Passport number: _____
_____ Country of residence: _____

2. JOURNEY DETAILS

TIC Policy No.		Name of Corporate (if applicable)	HLP TRAVEL SOLUTIONS

Period of travel and destination you travelled to:

Departed on: _____ Returned on: _____
Main destination: _____

3. BANKING DETAILS (Payments cannot be made into credit cards)

Account Holder: _____ Bank: _____
Account/IBAN No. _____ Branch Location: _____
Branch/Swift Code: _____ Account Type: _____

4. CLAIM INFORMATION

Date of Incident/Loss: _____ Country where incident occurred: _____
Did you notify the Assistance Company?: YES/NO Assistance Company reference: _____

Provide a detailed description of your claim:

5. MEDICAL CLAIM INFORMATION

1. Emergency Medical Treatment received as a result of (Please mark with X)

Injury ☐ Illness ☐ Occupation ☐ Pre-Existing Condition ☐ Sporting Injury ☐

2. Diagnosis: _____

3. If you were hospitalised, please provide details of the Hospital where you were admitted

Name of Hospital: _____ Date of Admission: _____

Name of Consulting Dr: _____ Contact Number: _____

Have you been treated for this illness/disease within the last 6 months of purchasing your policy? YES/NO

If yes, provide further details:

_____

_____

_____

6. ITEMS CLAIMED

Date	Provider / Description	Settlement To	Amount
		Provider */ Claimant#	US$
		Provider */ Claimant#	US$
		Provider */ Claimant#	US$
		Provider */ Claimant#	US$
		Provider */ Claimant#	US$
		Provider */ Claimant#	US$
		Provider */ Claimant#	US$

* Provider means the medical provider or supplier

Claimant means the person receiving the medical attention

CHECK LIST – What to include with your submission			
Medical Reports from treating doctors		All Receipts for accounts paid	
All Medical Accounts/Invoices			

Completed claim form and supporting documentation to be emailed to claims@tic.co.za

7. DECLARATION

I hereby confirm that I have answered all questions truthfully and have not withheld information that is material to the claim.

Signature: _____ Date: _____