MASSY | UNITED INSURANCE

Massy United Insurance Ltd.
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TRAVEL CLAIM FORM

VAT No. .....

Policy (or Certificate) No ..... **Branch or Agent to whom you paid your premium** .....

Name of Insured ..... **Occupation** .....

Address ..... **Telepone No.** .....

..... **Cell No.** .....

Email Address .....

PERSONAL LUGGAGE

Name and address of owner .....

.....

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Date of loss or damage .....**Time** ..... **a.m./p.m. Place** .....

Circumstance of loss or damage .....

.....

.....

Date advised to Police ..... **Address of Police Station** .....

If luggage or money is insured under any other Policy, name and address of Insurers .....

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DETAILS OF LUGGAGE

No. of Articles	Description	When Bought	Where Bought	Cost Paid	Amount Claimed

PERSONAL ACCIDENT/LOSS OF DEPOSITS

Name of Injured person ..... **Occupation** .....

Address ..... **Date of birth** .....

.....

Description of accident &/or illness .....

Date of accident ..... **Time** .....**a.m./p.m.** .....

Nature of injury .....

Name and address of doctor who attended .....

.....

Has a similar injury been sustained before? ..... **if so, when?** .....

Name and address of usual doctor .....

.....

During what period was the injured person totally disabled from attending to any part of his occupation or profession?

From .....**20** .....**To** ..... **20** .....

If total disablement continues, a medical certficate will be required from the injured person's usual doctor.
N.B. Declaration overleaf to be completed

FOR CLAIMS FOR 'LOSS OF DEPOSITS' PLEASE STATE

	HOTEL/ACCOM COSTS	TRANSPORT
1) Amount of Deposit		
2) Percentage returned by carrier		
Net amount claimed		

I declare that the particulars given on this form are, to the be□ of my knowledge, true and complete.

Date …… Signature of Insured ……

MEDICAL AND OTHER EXPENSES

Name of person concerned …… Date of birth ……

Address ……

……

Nature of injury or illness …… Date ……

Cause of injury or illness ……

……

……

……

Name and address of do□or who a□ended ……

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……

If the cause was illness, has the person concerned previously su□ered similar illness? ……

If so, when? ……

Details of expenses claimed ……

……

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Receipts and documents supporting this claim are to be sent with this form

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I declare that the particulars given on this form are, to the best of my knowledge, true and complete

Date …… ***Signature of Insured*** ……