TPL Insurance
Formerly TPL Direct Insurance

TRAVEL CLAIM FORM

1. INSURED NAME: _____
2. POLICY NO. _____
3. NATURE OF LOSS:
   - Medical
   - Flight Delay
   - Baggage
   - Loss of Passport
   - Trip Cancellation
4. DATE OF LOSS: _____
5. PLACE OF LOSS (City & Country): _____
6. CIRCUMSTANCES OF LOSS: _____
   _____
7. NAME OF HOSPITAL/CLINIC: _____
8. NATURE OF ILLNESS: _____
9. HAVE YOU EVER SUFFERRED FROM OR BEEN TREATED FOR THE SAME ILLNESS BEFORE? IF YES, GIVE DETAILS:_____
   _____
10. IN CASE OF FLIGHT DELAY:

    Scheduled Time: _____
    Actual Departure Time: _____

11. LOSS AMOUNT: _____

I /We hereby confirm that all the above mentioned facts are true to my knowledge. I/We further solemnly declare that I/We have no manner nor by any fraud nor willful misrepresentation nor non disclosure sought unjustly to benefit by this loss and that this solemn declaration made by me/us conscientiously believing the same to be true. I also authorize the insurance company to obtain any information, if needed for assessment of this claim, pertaining to my medical condition from any physician, hospital or medical facility.

_____
Insured's Signature