LUMA TRAVEL INSURANCE

TRAVEL CLAIM FORM

GENERAL INFORMATION

- ✓ For all claims, please submit:
  1. A completed and signed Travel Claim Form
  2. A copy of the Passport of the Insured with Exit and Entry Stamp, Boarding Pass and/or Travel Evidence of Insured Person
  3. Other documents as listed per Claim type (see following pages). Please note other documents may be requested by the Company on a case by case basis.

- ✓ For your record, please keep a copy of every document that you submit.

- ✓ If you are claiming more than one policy benefit, please complete each section as required.

- ✓ If you are unable to supply one of the required documents, please explain why so that we may consider how to progress with your claim.

- ✓ Please avoid sending the documents separately as they may lost in transition, resulting in a delay assessing your claims.

- ✓ **For claims exceeding USD 500, once the claim is approved, instructions will be provided to submit the original physical documents required by the insurer for claim payment processing.**

Contact LUMA:
hello@lumatravel.com

INSURED/POLICYHOLDER

Policy No.: _____

Insurance Period: From: _____ To: _____

Gender: ☐ Male ☐ Female

Name of Insured: _____

Birthday: _____

Passport/ID card No.: _____

Email Address: _____

Contact Address: _____

METHOD OF REIMBURSEMENT

Account Name: _____

Account Number / IBAN: _____

Bank Name: _____

Currency: _____

SWIFT Code / BIC: _____

Routing Number / BSB Number: _____

Important: The account holder name must match exactly the name of the Insured shown in the section above. Reimbursement cannot be made to a third party account. If the Insured is a minor, the account must belong to the parent or legal guardian, and proof of guardianship must be given (for example the minor's birth certificate naming the parent, or a legal guardianship document).

ACCIDENT/LOSS

Please submit:

Loss of Life:

1. A Death Certificate
2. An autopsy report, certified by the Case Officer or issuing authority
3. A police report, certified by the Case Officer
4. A copy of the Passport and house registration (stamp "death") of the Insured
5. A copy of the Passport and house registration of the Beneficiary
6. Original versions of legal documents of the legal heir (legal Beneficiary)

Dismemberment or Loss of Sight or Loss of Speech or Hearing or Total Permanent Disability:

1. A report of the Board of Medical Examiners/Board of attending Physicians certifying the Insured has suffered from total permanent disability or dismemberment or loss of sight, or loss of speech or hearing
2. A police report or proceedings about the accident which results in injury on the Insured
3. Medical records about post-accident treatment
4. A copy of the Passport and house registration of the Insured
5. A copy of the Passport and house registration of the Beneficiary
6. Original versions of legal documents of the legal heir (legal Beneficiary)

Date of Accident/Loss: _____

Time of Accident/Loss: _____

Place of Accident/Loss: _____

Brief Description of Accident/Loss:

_____

_____

Total amount claimed: _____ **USD**

MEDICAL EXPENSE

Please submit:

Medical Expense:

1. A Physician's Report stating the symptoms, diagnosis and the treatment given
2. Prescription showing details of date, names of medicines, quantities and doses/Hospitalization Cost
3. Original Financial/VAT Invoice with a breakdown of medical expenses; room & board

Hospital Cash Allowance:

1. A Physician's Report stating the symptoms, diagnosis and the treatment given
2. Summary of medical records/medical treatment records of the Insured
3. Discharge Certificate indicating the dates and time of being admitted to and discharged from the hospital
4. Certificate of Surgery or Medical Procedure in case treatment is given in the form of surgery

Date and Place of Injury or Illness: _____

Please describe the cause of Injury or Illness: _____

_____

Hospital and Doctor's name: _____

Have you ever suffered the sickness/injury or a similar condition or a recurrence of a previous illness/injury?

☐ No

☐ Yes

IF yes, please specify: _____

Total amount claimed: _____ USD

EMERGENCY MEDICAL EVACUATION AND REPATRIATION

Please submit:

Emergency Medical Evacuation and Repatriation:

1. Nomination of a Physician's for Emergency Medical Evacuation and/or Health Certificate for repatriation
2. A Physician's Report stating the symptoms, diagnosis and the treatment given
3. The Carrier's Report of Emergency Medical Evacuation and Repatriation
4. Original Financial Invoice with a breakdown of incurred expenses

Repatriation of Mortal Remains:

1. A Death Certificate
2. An autopsy report, certified by the Case Officer or issuing authority
3. A police report, certified by the Case Officer

Family Member Visit, Return of Children:

1. Medical records of the Insured
2. Invoice and copies of plane ticket of family member of the Insured to visit him/her, or returning the children of the Insured to the country of Origin
3. Death Certificate (in case the Insured has passed away)
4. A copy of the Passport of the family member/children

Additional Costs of Travel and Accommodation:

1. Medical records of the Insured.
2. Invoice and copies of plane ticket and/or Invoice of accommodation cost.
3. A copy of the Passport of the family member/travelling companion (in case paying for family member/companion)

Date of Event: _____

Place of Event:

_____

Brief Description of Event:

_____

_____

Total amount claimed: _____ **USD**

CANCELLATION/CURTAILMENT

Please submit:

Trip Cancellation:

1. Receipts of the Travel Agency or Carrier, receipts for accommodations and meals, stating the amount paid
2. A Physician's Report (in the case of Serious injury or Sickness of the Insured or of Family Members)
3. A Death Certificate (in the case of Death of the Insured or of Family Members)
4. All the boarding passes and air tickets

Trip Curtailment:

1. Receipts of the Travel Agency or Carrier, receipts for accommodations and meals, stating the amount paid
2. A Physician's Report (in the case of trip curtailment due to Serious Injury or Sickness of the Insured or of Family Members)
3. A Death Certificate (in the case of Death of the Insured or of Family Members)
4. All the boarding passes and air tickets

Booking time and place	Intended departure date	Date cancelled/curtailed	Cause	Remark

Total amount claimed: _____ **USD**

TRAVEL, FLIGHT AND BAGGAGE DELAY

Please submit:

Flight Delay:

1. All the boarding passes and air tickets
2. A letter certifying the flight delay issued by the responsible authority or the relevant commercial airline

Baggage Delay:

1. All the boarding passes and air tickets
2. A letter certifying the baggage delay issued by the carrier

Travel or Flight delay

Original travel or flight details	Delayed travel or flight details
Date:	Date:
Time:	Time:
Place of departure:	Place of departure:
Carrier or flight No.:	Carrier or flight No.:
Name of carrier or airlines:	Name of carrier or airlines:

Baggage delay

Travel or flight details	Collection of delay baggage
Arrival date:	Date:
Arrival time:	Time:
Place of arrival:	Place:
Carrier or flight No.:	
Name of carrier or airlines:	

Total amount claimed: _____ USD

BAGGAGE, PERSONAL EFFECTS, TRAVEL DOCUMENTS AND PERSONAL MONEY

Please submit:

Loss of or Damage to Baggage and/or Personal Effects contained in the Baggage:

1. A letter certifying the loss or damage or "Property Irregularity Report" issued by the carrier or the hotel management specifying details of loss or damage in the case the loss or damage occurred while under care of the carrier or hotel
2. A Police Report or Police Register issued by the local police

Loss of Travel Documents:

1. A letter certifying the loss issued by the hotel's management with details of the loss or damage
2. A Police Report or Police Register issued by the local police
3. Evidence of money exchange or the purchase of travelling cheques (if any)

Loss of or Damage to Personal Money:

1. A letter certifying the loss issued by the hotel's management with details of the loss or damage
2. A Police Report or Police Register issued by the local police
3. Evidence of money exchange or the purchase of traveler's cheques (if any)

Date and Place of Incident: _____

Please describe the cause of Incident: _____

Please itemize all lost or damage items:

Item/Description	Time and place of purchase	Original purchase price	Cost of repair	Claim amount

Total amount claimed: _____ **USD**

PERSONAL LIABILITY

Please submit:

1. Photographs (if any) and evidence showing the loss or damage occurred to the Third Party.
2. A Police Report or Police Register issued by the local police.
3. A Physician's Report and copy of the medical treatment receipts in the case of bodily injury of the Third Party.
4. Original Receipts & Invoice for the repair work in the case of property damage of a Third Party or receipts for the replacement items in the case of lost property.

Date and Place of Incident:

Please describe the cause of Incident:

Total amount claimed: _____ **USD**

CAR RENTAL EXCESS

Please submit:

1. The rental agreement of the car rental agency stating the excess amount to be responsible by the Insured imposed by the Insurance Contract of the car rental agency.
2. The certified written copy of the police report where the event has occurred.
3. Copy of driving license

Date and Place of Incident:

Please describe the cause of Incident:

Total amount claimed: _____ USD

OTHER INSURANCE

Is there any other policy(ies) covering the Insured in respect of this claim?

☐ No

☐ Yes

IF yes, please specify:

DECLARATION

I/we do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I/we agree that if I/we have made or in any further declaration in respect of the said claim shall make any false or fraudulent statements of suppress conceal or falsely state any material fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited.

I/we hereby authorize any hospital physician, other person who has attended or examined me, to furnish upon request to Bao Long Insurance Corporation, or its authorized representative, any or all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date:

Signature of the Insured