



**LAFERLA**

INSURANCE AGENCY LIMITED

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**MIDDLESEA**

A MEMBER OF THE **MAPFRE** GROUP

# travel INSURANCE CLAIM FORM

## IMPORTANT NOTE

Insurers, their Agents and Insurance Associations share information with each other to prevent fraudulent claims and for underwriting purposes. In the event of a claim, some or all the information you supply on this form and the proposal form together with other information relating to the claim may be provided to other Insurers, their Agents and Insurance Associations.

## ALL RELEVANT QUESTIONS MUST BE FULLY ANSWERED

### 1. GENERAL SECTION (THIS SECTION MUST BE COMPLETED BY ALL CLAIMANTS)

Title	Name and Surname of policyholder		
Policy no.	Travel scheme <small>(if applicable e.g. BOV card holder, La Vallette, Flypass etc.)</small>		
Claimant's name			
Address			
I.D. card no.	Passport no.		
Tel/Mob. no.	E-mail address		
Date of birth	Business or occupation		
Status of claimant	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated <input type="checkbox"/> Divorced
Date of departure	Date of return		
Destination/Countries			
Purpose of journey	<input type="checkbox"/> Holiday	<input type="checkbox"/> Business	<input type="checkbox"/> Other <small>(please specify)</small>
Are you insured by any other policy in respect of this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "YES", please give name and address of Insurers and policy number			
Have you ever before claimed under a travel policy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "YES", please give details of the claim			

## 2. CANCELLATION AND ABANDONMENT

Date of cancellation/abandonment

Please give reasons for cancellation/abandonment.

If the reason is related to DEATH, INJURY or ILLNESS please complete **SECTION 6 - MEDICAL INFORMATION**

State amounts claimed and attach receipts

Was the travel agent or ticket issuing office notified immediately of the cancellation?

Yes

No

Please specify the amounts recovered, if any (Attach any relevant booking conditions)

Number of persons claiming

## 3. PERSONAL ACCIDENT (PLEASE ALSO COMPLETE SECTION 6 - MEDICAL INFORMATION)

Date of accident

Time of accident

Place of accident

Give full description of the circumstances and details of the injury

Has claimant been totally disabled as a result of this accident?

Yes

No

When did total disablement start?

Is claimant still totally disabled?

Yes

No

When does claimant expect to resume part, if not all, normal business?

## 4. MEDICAL EMERGENCY AND ASSOCIATED EXPENSES (PLEASE ALSO COMPLETE SECTION 6 - MEDICAL INFORMATION)

Give details of injury or illness necessitating medical attention

Date of occurrence

Detail the expenses incurred (Attach receipts)

Please specify details of any Private Health Insurance which also covers you for the above expenses

**5. HOSPITAL BENEFIT (PLEASE ALSO COMPLETE SECTION 6 - MEDICAL INFORMATION)**

Reason for admittance to hospital	
Date admitted to hospital	Time admitted to hospital
Date discharged from hospital	Time discharged from hospital
Attach hospital report	

**6. MEDICAL INFORMATION (PLEASE COMPLETE FOR SECTIONS 2-5)**

Name and address of doctor giving initial treatment in respect of this illness or injury	
Has the person concerned ever suffered from this type of illness or injury before?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "YES" give details	
Did you know about this illness or injury prior to your departure from Malta?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name and address of usual doctor	
If "NOT" claimant, give name, address and relationship	
Has he/she been consulted in respect of this illness or injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**7. DELAYED AND MISSED DEPARTURE**

Reasons for delayed or missed departure	
Date of original departure	Time of original departure
Date of rescheduled departure	Time of rescheduled departure
Reasonable expenses incurred as a result of missed or delayed departure. (Attach receipts)	

**8. PERSONAL BELONGINGS AND PERSONAL MONEY (SECTION ALSO APPLICABLE TO LOSS OF PASSPORT AND DELAYED LUGGAGE)**

Date of loss, theft or damage	Time
Place	
State the precise circumstances in which loss, theft or damage occurred	
Name and address of witness/es	
Were the police notified of loss and/or theft? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "YES", when and at which station	

**LOSS OF PASSPORT** - List details and amounts claimed in respect of additional accommodation and travel expenses incurred if you lose your passport whilst you are abroad (Attach invoices/receipts)

**PERSONAL BELONGINGS**

Description of lost, stolen or damaged property (including make and model) or items bought as emergency expenses	Date of purchase	Original purchase price in EURO	Value at the time of loss after allowing for wear and tear in EURO	NET AMOUNT CLAIMED IN EURO
<b>TOTAL AMOUNT CLAIMED</b>				

**PERSONAL MONEY**

Currency	Amount
<b>TOTAL AMOUNT CLAIMED IN EURO</b>	

Please attach original receipts, invoices and/or proof of purchase.

I/We hereby declare that the above information and statements are, to the best of my/our knowledge and belief, correct and complete. If the answers to all or any of the above questions have been written by others at my/our dictation or instruction I/We confirm that I/We have read those answers and that they are correct.

Signature of policyholder	Date
Signature of claimant	Date