Star Assurance

No. C551/4 Cola Street Adjacent ATTC, Kokomlemle, P. O. Box 7532, Accra-North

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E-mail: sac@starassurance.com Website: www.starassurance.com

TRAVEL INSURANCE CLAIM FORM

POLICY NUMBER:……………………………………..…..INSURED'S NAME:…………………………………..…………………

ADDRESS:……………..……………………………..….……..Email Address:………….…………………..……………….……

BUSINESS/OCCUPATION:……………………………...…………..… DATE OF BIRTH:………………………………...…………..…

PERIOD OF INSURANCE: START DATE:……………………………..EXPIRE DATE:……………………………………….……

PASSPORT NO:………………………………………….….. TEL. NO:…………………..…………………………………………

1. Country Of Residence:…………………………………Country of Visit:……………………………..

2. Purpose of Visit:………………………………………………………………………………………

3. Date of Loss/Incidence:……………………………………………………………………………..

4. Please give the full narration of the incidence:………………………………………..……………..
……
………
………

5. How long were you hospitalized:…………………………..………………………………………..
……

6. (a) Name of Hospital you attended?..

   (b) What is the name and address of the doctor attending to you?...
   (Please attach a Medical Report from the Hospital)

7. Have you required medical or surgical treatment during the past five years?
   Is so, please give particulars:
……
……
………..

8. For Baggage loss; a) was the incident reported to the Police?:………………………………………

   b) Was the incident reported to the Airline?...

9. List of Missing items:……………………………………………………………………………………
…….
…….

I HEREBY DECLARE THAT THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY/ OUR KNOWLEDGE AND BELIEF

Signature:…………………………………………… Date:……………………………………………….