

TUNE PROTECT TRAVEL STUDENT ASSURANCE

IMPORTANT NOTICE: To enable us to process your claim as quickly as possible, it is important to complete this form accurately and provide us with the original documentation requested at your own expense. If the information/documents supplied are insufficient, we shall advise you if further information / documents are required. Upon completing this form, please send the claim form and all supporting documentations to our servicing agent: **Tune Protect Commercial Brokerage LLC, Blue Bay Tower, Level 8, No. 807, Business Bay, Dubai, UAE**
P.O. Box: 124177

Please answer all questions and boxes where appropriate. Leaving a question blank may result in delays in settling your claim.

Policy Certificate Number:
 Policyholder's Name:
 ID No: Passport No:
 Contact No: (Office)..... (House)..... (Mobile).....
 Claimant's Name (as per ID / Passport):
 ID No: Passport No:
 Contact No: (Office)..... (House)..... (Mobile).....
 Address: Postcode:
 Email Address:

CLAIMANT'S BANK DETAILS (FOR BAHRAIN ACCOUNT ONLY)

Account Name:..... **(Note: Payment can only be made to Policyholder)**
 Bank Account No: Bank Name and Location:
 SWIFT Code / Bank Identification Code (BIC): IBAN No:

Please fill in the flight information. Leaving this section blank would result in delays in settling your claims.

Airline: Flight No: Passenger Name Record (PNR) No / Booking No:

First Departure Country

Scheduled First Departure Date (dd/mm/yyyy):
 Scheduled Return Date (dd/mm/yyyy):

I am filing a claim in respect of: - (Please the relevant boxes and fill in the blanks)

SECTION 1: TYPE OF CLAIM	
1. PERSONAL ACCIDENT BENEFITS	
Accidental Death <input type="checkbox"/>	Total Permanent Disablement <input type="checkbox"/>
Date of Accident (dd/mm/yyyy):	Time: <input type="checkbox"/> am <input type="checkbox"/> pm
Description of incident/Injury:	
Nature of Injury:	
Are there any other insurance policies covering you for this incident? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If "Yes", please specify name of insurer, policy number and amount recoverable.	
Insurer:	Policy No.:Amount:



2. MEDICAL BENEFITS	
(a) Accidental & Sickness Medical Reimbursement	<input type="checkbox"/>
(b) Emergency Dental Treatment	<input type="checkbox"/>
(c) Compassionate Visit	<input type="checkbox"/>
(d) Medical Expenses for Inter Collegiate Sports injuries	<input type="checkbox"/>
(e) Treatment of Mental & Nervous Disorders	<input type="checkbox"/>
(f) Inpatient Hospitalization expenses related to Pregnancy/Childbirth	<input type="checkbox"/>
(g) Cancer Screening and Mammographic Examinations	<input type="checkbox"/>
3. EVACUATION & REPATRIATION BENEFITS	
(a) Emergency Medical Evacuation	<input type="checkbox"/>
(b) Repatriation of Mortal Remains	<input type="checkbox"/>
4. TRAVEL INCONVENIENCE BENEFITS	
(a) Loss of Passport	<input type="checkbox"/>
(b) Fraudulent charges	<input type="checkbox"/>
5. BAGGAGE BENEFITS	
(a) Baggage Delay	<input type="checkbox"/>
(b) Loss or damage of baggage and personal effects	<input type="checkbox"/>
6. OTHER BENEFITS	
(a) Personal liability	<input type="checkbox"/>
(b) Bail bond	<input type="checkbox"/>
(c) Sponsor protection	<input type="checkbox"/>
(d) Study interruption	<input type="checkbox"/>

DECLARATION	
<p>I declare that the particulars stated above are true and correct and I understand that if I have in this or any further declaration in respect of this claim, make any false or fraudulent statement or suppress, conceal or falsely state any material fact whatsoever my claim may be declined.</p>	
<p>..... Name</p>	<p>..... Signature</p>
<p>Date: / /</p>	



SECTION 2: CHECKLIST ON THE REQUIRED SUPPORTING DOCUMENTS BY TYPE OF CLAIM

The following checklist will help you assemble the documents required to support your claim

- Please note:**
- i) **Dependent upon the circumstances, we may require other evidence to support your claim; in which casewe will contact you.**
 - ii) **Failure to provide the supporting documents may result in a delay of your claim.**
 - iii) **Please provide translation if the supporting document is not in English, at your own expense.**

COMPULSORY FOR ALL TYPES OF CLAIMS Certificate of Insurance Copy of Flight Itinerary
 Boarding pass as proof of departure or return

PERSONAL ACCIDENT BENEFITS

ACCIDENTAL DEATH AND PERMANENT DIABLEMENT

- Original medical bills / invoices
- Original medical Specialist report where required
- Photograph of injury
- Original or certified true copy of police report of the accident.
- Original copy of Death Certificate, burial permit and post-mortem report where applicable

AND SICKNESS MEDICAL REIMBURSEMENT

- Original medical bills / invoices
- Original receipts issued by the clinic / hospital
- Original medical report from the attending doctor

EMERGENCY DENTAL TREATMENT

- Original medical bills / invoices
- Original receipts issued by the clinic / hospital
- Original medical report from the attending doctor

COMPASSIONATE VISIT

- Recommendation Letter from the attending doctor to confirm that the Insured should be accompanied by another person during his/her admission in hospital.
- Receipt of expenses incurred i.e. hotel accommodation and transportation charges
- Boarding pass of the person accompanying the Insured.
- Proof of relationship with insured.

MEDICAL EXPENSES FOR INTER COLLEGIATE SPORTS INJURIES

- Original medical bills / invoices
- Original receipts issued by the clinic / hospital
- Original medical report from the attending doctor
- Proof of event organize by Educational Institution

TREATMENT OF MENTAL & NERVOUS DISORDERS

- Original medical bills / invoices
- Original receipts issued by the clinic / hospital
- Original medical report from the attending doctor

INPATIENT HOSPITALIZATION EXPENSES RELATED TO PREGNANCY & CHILDBIRTH

- Original medical bills / invoices
- Original receipts issued by the clinic / hospital
- Original medical report from the attending doctor

CANCER SCREENING & MAMMOGRAPHIC EXAMINATIONS

- Original medical bills / invoices
- Original receipts issued by the clinic / hospital
- Original medical report from the attending doctor
- Doctor's recommendation for cancer screening and mammography.

EMERGENCY MEDICAL EVACUATION

- Original bills and receipts by ambulance operator/hospital
- Original medical report from the treating doctor

REPATRIATION OF MORTAL REMAINS

- Original bills and receipts by ambulance operator/hospital
- Original medical report from the treating doctor

LOSS OF PASSPORT

- Copy of the report filed with the Airline/Airport or Police at place of loss within 24 hours
- Original receipts and proof of payment for all emergency expenses
- Receipt of expenses paid to get replacement travel documents

FRAUDULENT CHARGES

- Dispute form from the credit card company
- Credit card statement
- Police report

BAGGAGE DELAY

- Written confirmation of length of delay from airline (Property Irregularity Report)

LOSS OR DAMAGE OF BAGGAGE & PERSONAL EFFECTS

- Authority (Airline) confirmation letter stating compensation amount
- Original repair bill (damage items)/purchase receipts or warranty card of lost/damaged items
- Photographs of damaged items
- Property Irregularity Report from the airline



<p>PERSONAL LIABILITY</p> <ul style="list-style-type: none"><input type="checkbox"/> Correspondences (if any) between Insured and Third-party Claimant<input type="checkbox"/> Demand letter from Third Party claimant<input type="checkbox"/> Eyewitness report or statement<input type="checkbox"/> Original or certified true copy of police report where applicable<input type="checkbox"/> Photographs (if any)	<p>BAIL BOND</p> <ul style="list-style-type: none"><input type="checkbox"/> A copy of Police report<input type="checkbox"/> A copy of arrest warrant<input type="checkbox"/> Proof/Details about the offence<input type="checkbox"/> Order of court/legal notice
<p>SPONSOR PROTECTION</p> <ul style="list-style-type: none"><input type="checkbox"/> A copy of Legal Document<input type="checkbox"/> Original medical report from the attending doctor<input type="checkbox"/> A copy of Death Certificate of Insurance<input type="checkbox"/> A physician's statement giving the cause of death<input type="checkbox"/> All relevant medical reports<input type="checkbox"/> Police report lodged<input type="checkbox"/> Proof of payment from Sponsor<input type="checkbox"/> Name of sponsor and proof of relationship with Insured Person	<p>STUDY INTERRUPTION</p> <ul style="list-style-type: none"><input type="checkbox"/> Original medical report from the attending doctor<input type="checkbox"/> Original bill and receipts by ambulance operator/hospital<input type="checkbox"/> A copy of the Death Certificate<input type="checkbox"/> A proof relationship between Insured Person and Deceased.