



**PACIFIC CROSS**  
excellence at every contact

## TRAVEL INSURANCE CLAIMS FORM

Please send all claims and inquiries to: **Pacific Cross Insurance Company Limited c/o International Services Pacific Cross**  
Chaze Plaza Tower 19<sup>th</sup> Floor, Jl. Jend. Sudirman Kav. 21 Jakarta 12920, Indonesia  
Tel: +62 21 2598 9878 Fax: +62 21 2598 9879  
E-mail: [agency.broker@pic-indo.com](mailto:agency.broker@pic-indo.com) Website: <http://www.pacificcross.co.id>

Insurance Certificate No.		Claim No. (Office Use)
Name of Claimant		Date of Birth (MM/DD/YY)
Passport or Government I.D. No.	Postal Address	
Phone No.	Fax No.	E-mail

### Baggage & Personal Effects / Baggage Delay / Loss of Travel Document / Personal Money / Hole-in-one / Golfing Equipment

Date, time and place of incident	
State the occurrence of the incident	
Amount Claimed	Name of Payee

Please give particulars of items claimed

Item(s)	Original Cost	Date of Purchase

Any other insurance policy covering the items claimed? e.g. credit card protection plan, householder all risk Yes ☐ No ☐

If yes, please provide the following information.

Name of Insurance Company	Class of Insurance	Policy No.
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**Remarks:** Please attach the relevant supporting documents to certify the expenses / losses and incident and items of claim. e.g. airlines baggage irregularity report, original police reports, original purchase receipts of the items claimed, certificate issued by a recognized Golf Club.

**Medical Expenses / Emergency Assistance Services**

Date, time and place of incident		
Diagnosis of conditions / Cause of injury		
Amount Claimed		
Any other insurance policy covering the expenses involved? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, please provide the following information.		
Name of Insurance Company	Class of Insurance	Policy No.
<b>Remarks:</b> Please attach the relevant medical report and original medical expenses receipts to certify the expenses.		

**Curtailment of Trip / Cancellation Charges**

Causes of Claims		
Amount Claimed	Name of Payee	
Name, address, phone no. and contact person of Travel Agent		
Any other insurance policy covering the expenses involved? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, please provide the following information.		
Name of Insurance Company	Class of Insurance	Policy No.
<b>Remarks:</b> Please attach the relevant supporting documents to certify the expenses and incident of claim. e.g. medical report, death certificate, original receipts of amount claimed etc.		

**Travel Delay**

	Date / Time	From	To	Flight No.
Original Schedule				
Delayed Schedule				
Reason of Delay		Hours Delayed		
Any other insurance policy covering the expenses involved? Yes <input type="checkbox"/> No <input type="checkbox"/>				
If yes, please provide the following information.				
Name of Insurance Company	Class of Insurance		Policy No.	
<b>Remarks:</b> Please attach the relevant supporting documents to certify the hours delayed. e.g. copy of boarding pass and / or airticket, confirmation from Airlines / Travel Agent.				

## Personal Accident

Date, time and place of accident

State the occurrence of the accident

Please give particulars of the next of kin(s) of the Insured Person.

Name	Age	Address	Relationship	Passport or Government I.D. No.

**Remarks:** Please attach the supporting documents. e.g. accident report, police report, death certificate and / or any relevant documents.  
If the next of kin(s) is / are minors (persons under 18 years of age) please give particulars of the official Administrator(s) and provide copies of the documentation authorizing that person to act in this capacity.

## Authorization and Declaration

I hereby authorize any hospital, physician, or other person and / or authority who has attended or examined me, to furnish to **Pacific Cross Insurance Company Limited** or its authorized representative and permit the said insurance company (or its representative) to view any and all information requested with respect to my loss, illness or injury, medical history, consultation, prescription or treatment, and copies of police reports, accident reports, airlines or other carriers irregularity reports, statements, all hospital or medical records. A photostat copy of this authorization shall be considered as effective and valid as original.

I declare to the best of my knowledge and belief that the above statements and particulars to be true and correct. I further understand and agree that if I have made or shall make any false statement or concealment, all rights to recovery under the Policy shall be forfeited.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Claimant

## Notes

1. By furnishing this form the Company makes no admission of liability.
2. All original itemized bills, copy of round trip air ticket and copy of the Insurance Certificate must be submitted together with this form in order to avoid delay.
3. Claims will not be processed unless authorization and declaration are signed by the claimant.

**Supplementary Sheet for claims detail**

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*For Claims Department use only*