

To help us process your claim quickly, please follow these guidelines:

1. Complete a separate claim form for each claim and for each insured person.
2. If you are submitting a claim following an accident or injury, please complete in full Sections A, B & G.
3. If you are submitting a claim for a non-medical incident or personal luggage loss, please complete Sections A, (C - E as appropriate) & G.
4. If you are submitting a Personal Accident claim, please complete Sections A, F & G.
5. Whenever you or a other insured person receive medical treatment, the Claimsreport Service Provider TRIAS World should be completed by the medical provider. This report must always be submitted when submitting a claim following an accident or injury.
6. Please send this fully completed form to Assuria Medische Verzekering claims administration office, along with ALL original bills relating to the claim, plus proof of travel (e.g., email confirmations of trip, booking invoices, tickets.)
7. Please send completed claim form and supporting documents to:

SURINAME

Paramaribo:

Henck Arronstraat 5-7, Paramaribo

P: 473400 extension: 352, 351

F: 597-470895

Nickerie:

R.P. Bharosstraat 68, Nw Nickerie

P: 597-231911, 597-231757

F: 597-231912

GUYANA

Assuria General (GY):

Lot 133 Church Street

South Cummingsburg, Georgetown

P: 226-7052, 226-7074

F: 226-7123

8. All claims MUST be submitted to Assuria within 90 days from the incident.

A. DETAILS OF INSURED

TYPE OF POLICY

Trias Single Trip

Policy number :

Trias Multi Trip

Policy number :

POLICY HOLDER DETAILS

Name (Last, First, MI):

Date of birth :

Policy Number / Reference Number:

Address :

Postal Code / Zip :

Phone Number :

E-mail :

Fax :

Policy Currency :

US\$

CLAIMANT DETAILS

Name (Last, First, MI):

Address :

Postal Code / Zip :

Phone Number :

Occupation :

Was journey :

Holiday Business

Dates of journey :

From:

To:

Is the claim the result of an accident? Yes No

PLEASE LIST DOCUMENTS ENCLOSED:

Sections B-F of this form should be completed by the Insured Person who is the Claimant or (in the case of a minor) the parent or guardian.

B. MEDICAL EXPENSES & HOSPITAL BENEFIT

Nature of illness/injury:

Date and time of illness/injury:

Please confirm where the illness/injury took place:

Please provide a detailed description of how the injury occurred:

[Redacted]

Name and address of doctor(s) and/or hospital(s) from which treatment was received:

[Redacted]

Details of claimant's personal family physician / doctor :

Name (Last, First, MI):

[Redacted]

Address:

[Redacted]

Phone Number :

[Redacted]

Fax Number :

[Redacted]

Email :

[Redacted]

If treatment was given in hospital as an inpatient please confirm the dates:

[Redacted]

Was the Emergency Assistance Company contacted:

Yes No

If no, please state the reason why not:

[Redacted]

Was the insured Person pregnant:

Yes No

If yes, how many weeks?

[Redacted]

If the Insured Person has suffered illness, has he/she suffered from this before:

Yes No

If yes, please provide details:

[Redacted]

Does the Insured Person have Private Medical Insurance:

Yes No

If so, please provide the insurance carrier details including name, address and policy number:

[Redacted]

FOR EU CITIZENS ONLY

Was an EHC (European Health Card) taken on the trip:

Yes No

Was this presented to the hospital/doctor?

Yes No

Please submit all medical invoices and receipts which are relevant to your claim. A delay in submitting this documentation could result in a delay in the settlement of your claim.

C. MISSED DEPARTURE

Reason for missed departure:

[Redacted]

MISSED DEPARTURE

Point of departure:

[Redacted]

Point of Missed Connection:

[Redacted]

Method of transport being used to arrive at departure point:

[Redacted]

Please confirm how you recommenced trip:

[Redacted]

Amount claimed:

[Redacted]

D. BAGGAGE, PERSONAL EFFECTS, MONEY & DOCUMENTS

Date of loss or damage:

Time:

Please provide a detailed description of how the loss/damage occurred, including the location:

Please confirm when the loss/damage was reported and to which authority (e.g., police/airline/tour operator/hotel, etc.), including complete address and reference:

If the loss relates to travellers cheques/ cheques / cash / credit, bankers or charge card please confirm when the issuer was notified:

- If the loss occurred at the airport or on the aircraft we will require the Property Irregularity Report and this should be sent with this claim form.
- Please provide proof of the original purchase/ownership, i.e., receipts, bank/credit card statements, photographs, packaging, instructions manuals, valuations.
- Please note that we may make a deduction on the claim if proof of purchase is not provided and/or if wear-and-tear is applicable.
- If items have already been replaced please send the replacement invoice or receipt.

ITEM DETAILS

Full description of item 1:

Where purchased and date purchased:

Price paid:

Cost now:

Amount claimed:

Full description of item 2:

Where purchased and date purchased:

Price paid:

Cost now:

Amount claimed:

IMPORTANT

In the event of a personal baggage loss, all incidents MUST be reported to the local police within 24 hours. An incident number and loss report must be obtained and submitted to Assuria Medische Verzekering N.V.

Please provide details of any other insurance policy that you have that may contribute to this loss, e.g., household insurance, private medical insurance, personal travel insurance, credit card insurance, etc.:

Name of Insurer:

Policy Number:

Correspondence Address:

E. LOSS OF PASSPORT

Please confirm where the passport was lost:

Please provide details of the expenses incurred to replace the passport, including receipts:

F. PERSONAL ACCIDENT

When did the injury, or (in the event of a fatality) death occur?

Please detail the nature of the loss or how the death occurred:

Was the injury or cause of death as a result of natural causes?: Yes No

If yes, please give details:

In the event of a fatality, a Death Certificate issued by a licensed authority must be obtained, with the original copy being submitted to Assuria Medische Verzekering N.V.

For claims involving **Personal Liability**, **Legal Expenses** and **Hijack** please contact Assuria directly with details of the incident.

G. DECLARATION

For Data Protection Purposes I/We acknowledge that any personal data secured from me/us as a result of this claim will be held and processed for insurance administration and claims investigation. For this purpose, the information may also be passed to selected third parties and reinsurers.

I/We consent to your processing of sensitive data about me/us and other persons who may be insured under the contract.

I/We understand that all personal data I/We supply must be accurate and I/We have the specific consent of those other persons insured to disclose their personal data.

I/We consent to the inquiry of information from other insurers, Credit and other information Agencies to check the answers we have provided and will authorize the release of such information.

I/We declare that on settlement I/We transfer all rights of subrogation and recovery to the Insurer and or/their Loss Adjuster. Please note that we have rights to salvage and we will exercise these rights where applicable.

I/We declare that, to the best of our knowledge, the information submitted in this form is correct and complete.

Insured Person

Name :

Signature :

Date :

Policy Holder

Name :

Signature :

Date :