General Insurance
PO Box 10163 Jeddah – 21433 Phone: +966 2 6603733 Fax: +966 2 6651895

TRAVEL INSURANCE

Claim Form *Confidential*
The issue of this claim form is in no way an acceptance of liability.

Policy Type:______________
Policy No. _______________

To help us proceed with your claim quickly, please read carefully and answer all the questions below as applicable

✉ **Enclose** this form together with the following original documents:
- Copy of your insurance certificate
- Original prescriptions and invoices.
- Medical report and/or information clarifying the diagnosis & the treatment done.
- Passport copies showing the exit & entry dates:

Mail your complete claim to: Trade Union Cooperative Insurance Co. Al Hamra Plaza, , 4th Floor, Palestine Street, PO Box 10163 Jeddah – 21433 Phone: +966 2 6603733 Fax: +966 2 6651895

A Claimant Information

1. Policy No. : __________________________ **2.** Date of Birth : ☐☐ / ☐☐ / ☐☐ (Day/Month/Year)

3. Insured Name*:* ____ 4. Telephone No. ____________________

5. Address: ____

6. E-mail: ____

B Claim Information for accident or illness

4. Did you call the TUCI IS: ☐ no ☐ yes, when: ____

ILLNESS (if necessary use a separate sheet*)*

10. Date at which first symptoms appeared: ☐☐ / ☐☐ / ☐☐ (Day/Month/Year)

11. State nature of illness (exact nature of pathology): ____

12. Have you already been treated (including prescribed medicines) for this condition or any related condition prior to your subscription to the Plan? If yes, please specify: ____

a- *When? :* ☐☐ / ☐☐ / ☐☐ (Day/Month/Year)

b- *What treatment? :* ____

c- *Name of physician who treated you :* _______________________ *d* Telephone No. ______________________________

e- *Address :* ____

ACCIDENT (if necessary uses a separate sheet*)*. PLEASE ATTACH POLICE REPORT WHERE APPLICABLE.

5. Date of accident: ☐☐ / ☐☐ / ☐☐ .(Day/Month/Year*)***6.** Place of accident: ______________________________

7. Nature of injuries: ____

8. What happened? : ____

____

9. If any Third Party is involved, please specify:

a- *Name :* _______________________________ ***b-*** *first name : .* ______________________________

c- *Address :* ____

d- *Telephone :* _____________________ ***e-*** *Fax :* _____________________ *Email :* ___________________________

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BAGGAGE DELAY/ LOSS
Please attach following documents along with the claim form
1. Copy of your ticket showing the itinerary
2. Copy of Baggage Tags
3. PIR + A dated official confirmation letter from the Airlines showing that the baggage is lost or delayed (duration of delay)
4. Original invoices of the reasonable emergency expenses incurred due to delay/ loss of baggage
5. Copy of cheque or any compensation paid by the airlines

a – Date of Travel ______________________________ b- Name of Airlines ____

c – Date, time and place of departure and arrival ____

d – Date and time when you received your baggage from Airlines____

f – List of reasonable emergency expenses you incurred due to delay/ loss

g – In case of baggage loss, list of items in the bag and their price. Attach a separate sheet if necessary

TRAVEL DELAY
Please attaché following documents along with the claim form
1. Copy of your ticket showing the original itinerary
2. Copy of boarding pass of actual travel
3. A dated official confirmation letter from the Airlines stating the reason for delay and duration of delay.
4. Original invoices of the reasonable emergency expenses incurred due to delay
5. Copy of cheque or any compensation paid by the airlines

Planned Travel

a – Date & time of Travel ______________________________ b- Name of Airlines ______________________________________

Delayed travel

a – Date & time of Travel ______________________________ b- Name of Airlines____

b – List of reasonable emergency expenses you incurred due to delay/ loss

Description	Date & Time of Purchase	*Purchase Price

Statement and authorization:

In order to process this claim, I authorize my physician, hospital or other medical provider to release to TUCI, any information regarding my medical history, symptoms, treatment, examination result or diagnosis, invoices. A photocopy of this authorization shall be considered as effective and valid for the duration of the claim, but not to exceed one year from the date signed. I declare to the best of my knowledge that the above information is true.

Date and Signature: ______________________ ________________ ________________________________