GeoVisions

TIC TRAVEL INSURANCE CONSULTANTS
Travel Assured

CLAIM FORM

Please complete ALL fields. Take note of the Supporting Documentation required on the Check List.

1. PERSONAL DETAILS

Claimant details

Title: ______________________ Contact number: ______________________
First name: ______________________ Email address: ______________________
Surname: ______________________ Date of birth: ______________________
Current Address: ______________________ ID/Passport number: ______________________
______________________ Country of residence: ______________________

2. JOURNEY DETAILS

TIC Policy No.		Name of Corporate (if applicable)	HLP TRAVEL SOLUTIONS

Period of travel and destination you travelled to:

Departed on: ______________________ Returned on: ______________________
Main destination: ______________________

3. BANKING DETAILS (Payments cannot be made into credit cards)

Account Holder: ______________________ Bank: ______________________
Account/IBAN No. ______________________ Branch Location: ______________________
Branch/Swift Code: ______________________ Account Type: ______________________

4. CLAIM INFORMATION

Date of Incident/Loss: ______________________ Country where incident occurred: ______________________
Did you notify the Assistance Company?: YES/NO Assistance Company reference: ______________________

Provide a detailed description of your claim:

5. MEDICAL CLAIM INFORMATION

1. Emergency Medical Treatment received as a result of (Please mark with X)

Injury ☐ Illness ☐ Occupation ☐ Pre-Existing Condition ☐ Sporting Injury ☐

2. Diagnosis: ______________________________
3. If you were hospitalised, please provide details of the Hospital where you were admitted

   Name of Hospital: ____________________ Date of Admission: ____________

   Name of Consulting Dr: ____________________ Contact Number: ____________

   Have you been treated for this illness/disease within the last 6 months of purchasing your policy? YES/NO
   If yes, provide further details:

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6. ITEMS CLAIMED

Date	Provider / Description	Settlement To	Amount
		Provider */ Claimant#	US$
		Provider */ Claimant#	US$
		Provider */ Claimant#	US$
		Provider */ Claimant#	US$
		Provider */ Claimant#	US$
		Provider */ Claimant#	US$
		Provider */ Claimant#	US$

* Provider means the medical provider or supplier
# Claimant means the person receiving the medical attention

CHECK LIST – What to include with your submission			
Medical Reports from treating doctors		All Receipts for accounts paid	
All Medical Accounts/Invoices			

Completed claim form and supporting documentation to be emailed to claims@tic.co.za

7. DECLARATION

I hereby confirm that I have answered all questions truthfully and have not withheld information that is material to the claim.

Signature: ______________________________ Date: ____________

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