Berkshire Hathaway Specialty Insurance

Accident & Health

CORPORATE TRAVEL INSURANCE CLAIM FORM

INSTRUCTIONS AND IMPORTANT NOTES:

Please complete the sections of the claim form relevant to the claim you wish to make.

1. The claim form must be submitted to BHSI within thirty (30) days after the occurrence of the matter or loss giving rise to the claim.
2. It is very important that all relevant sections of the policy are completed as fully and as accurately as possible and that supporting documentation is provided with the claim. For details of the documentation and information typically required in support of a claim please see our website: https://bhspecialty.com/claims/claims-singapore/ah-claims-guide.

   Copy/scanned documents may be provided although we reserve the right to ask for original documentation. We also reserve the right to ask for documents and information in addition to that which you submit with your claim form.

   If in any doubt as to the information or documentation required for your claims submission please contact our claims team (details below).
3. Each claim will be reviewed and assessed on its own merits and all settlement decisions shall be determined according to the terms and conditions of your Policy.
4. Acceptance by BHSI of your claims submission does not represent an admission of policy liability on the part of BHSI.
5. Claims settlement and payment shall be made in accordance with the relevant policy terms and conditions.

CLAIMS SUBMISSION AND ENQUIRY:

All claims submissions and enquiries may be sent to BHSI using the email address below:
AsiaAHclaims@BHspecialty.com

Should you wish to mail your claim to BHSI, our address in Singapore is below:

Berkshire Hathaway Specialty Insurance
Accident & Health Claims Dept
30 Cecil Street
Level 12 Prudential Tower
Singapore 049712

If you wish to speak to our claims team for assistance before submitting your claim please call:
Singapore: +65 6904 4622

A. YOUR INFORMATION

BHSI Policy Number:

Name of your Employer / the Policyholder: _____

Your Full Name: _____

Your Position: ☐ CEO ☐ CFO ☐ COO ☐ CRO ☐ CIO ☐ Director ☐ Head of HR
☐ GM ☐ Company Secretary ☐ Employee ☐ Contractor

If none of the above positions, please specify (e.g. Spouse or Dependent Child):

_____

Your Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ other Your Date of Birth: _____ (DD/MM/YYYY)

Your NRIC/Passport No.: _____ Nationality: _____

Country of Residence: _____ Country of Assignment: _____

Your Contact Details:

Home Address: _____ Country: _____ Postcode: _____

Telephone: _____ Mobile: _____

Email Address: _____

B. TRAVEL INFORMATION

Date of Departure: _____ (DD/MM/YYYY) Date of Return/Expected Return: _____ (DD/MM/YYYY)

Reason for Travel: ☐ Business ☐ Business & Leisure ☐ Leisure ☐ Other

If other, please specify: _____

Departure Country: _____ Departure City: _____

Destination Country: _____ Destination City: _____

C. EMERGENCY ASSISTANCE PROVIDER – BHSI CARE & CONCIERGE

Has BHSI Care & Concierge been advised of the claim? ☐ Yes ☐ No

If yes, please provide Case Number: _____

D. OTHER INSURANCE

Did you pay for your trip on a Credit Card? ☐ Yes ☐ No

If yes, please provide the name of the financial institution and card type (e.g. Platinum or Gold Visa): _____

Did you purchase any other travel insurance policy for this trip? ☐ Yes ☐ No

If yes, please provide the name of the travel insurance provider & your policy number: _____

Do you have Home & Contents Insurance? ☐ Yes ☐ No

If yes, please provide the insurer name and policy number:

_____

Are you covered for Private Health Insurance? ☐ Yes ☐ No

If yes, please provide details (Insurer, Policy Number, etc.)

Have you lodged a claim with your insurer for any medical expenses? ☐ Yes ☐ No

If yes, please provide all claim and rebate details:

E. OVERSEAS MEDICAL EXPENSES CLAIM

Injury/Illness/Sickness or Disease Information

(Please provide itemised bills and invoices. Please also provide medical reports (if applicable) for all medical expenses claimed.

Describe the injury/illness/sickness or disease requiring medical assistance/treatment:

Date on which the injury was first suffered or you first had symptoms of the illness/sickness/disease requiring medical assistance/treatment: _____
(DD/MM/YYYY)

Country in which medical treatment or assistance was first sought: _____

Was any treatment sought in your country of residence? ☐ Yes ☐ No

If yes, please provide further details:

Claim Information

Date Expense Incurred (DD/MM/YYYY)	Clinic/Hospital	Details of all Medical Treatment	Amount
		Total Amount Claimed	

If you are a U.S. citizen, have you submitted any medical bills to U.S. Medicare? ☐ Yes ☐ No

If yes, please provide:

Social Security Number: _____

Details of the bills concerned:

F. PERSONAL ACCIDENT AND WEEKLY BENEFITS

Did you/the Insured Person suffer an accident during your/their journey which resulted in a bodily injury? ☐ Yes ☐ No

Was the Insured Person fatally injured as a result of the accident? ☐ Yes ☐ No

Are you/the Insured Person prevented from performing your usual occupation as a result of the bodily injury? ☐ Yes ☐ No

Did you/the Insured Person suffer from a sickness during your/their journey? ☐ Yes ☐ No

Are you/the Insured Person prevented from performing your usual occupation as a result of the sickness? ☐ Yes ☐ No

If you have answered "Yes" to any of the questions above we may require you to complete an additional form to gather further information. Our BHSI representatives will advise you further in this regard.

G. CANCELLATION AND DISRUPTION CLAIM

Type of claim:

☐ Loss of Deposits ☐ Cancellation & Disruption ☐ Financial Insolvency ☐ Missed Transport Connection

☐ Overbooked Flights ☐ Travel Delay

Cause of claim:

☐ Insured Person's unexpected bodily injury, sickness or death

☐ Unexpected serious sickness or serious injury or death of an Insured Person's relative, colleague or travelling companion

☐ Unforeseen circumstances outside of the control of you or the Insured Person
Please use this section to describe the unforeseen circumstances:

☐ Refusal, failure or inability of any person, company or organisation to provide services, facilities or accommodation by reason of financial default or insolvency

☐ Missed travel connection due to unforeseeable circumstances outside your or the Insured Person's control

☐ Denied boarding because of overbooked flights

☐ Industrial action by the employees of the transport operator

☐ Mechanical fault of the conveyance intended to be used

☐ Bad weather

☐ Other reasonable cause beyond the control of the transport operator
Please use this section to provide further details:

Details of the changed itinerary (if applicable):

Date intended to travel (DD/MM/YYYY)	Dates actually travelled (DD/MM/YYYY)

Cities intended to travel to	Cities actually travelled to

Lost Travel and Accommodation Expenses

Airfares/Airline	Accommodation	Currency	Amount Paid	Amount Refunded	Amendment Cost	Cancellation Cost
Subtotal Amount Claimed						
Total Amount Claimed						

Additional Expenses Incurred

Expense Detail	Date Expense Incurred (DD/MM/YYYY)	Amount
Less any compensation received from airline, hotel etc.		
Total Amount Claimed		

H. BAGGAGE & PERSONAL EFFECTS CLAIM

Was your baggage delayed? ☐ Yes ☐ No

If yes, please provide the following details:

Date of arrival at destination:_____ Time of arrival at destination:_____
(DD/MM/YYYY)

Date on which baggage was received:_____Time at which the baggage was received: _____
(DD/MM/YYYY)

Have you received compensation from your transport operator? ☐ Yes ☐ No
If yes, please provide evidence of the compensation received.

Was your baggage or were your personal effects lost or damaged? ☐ Yes ☐ No

If yes, please provide a brief summary of the circumstances leading to the loss of/damage to baggage or personal effects:

Date on which the loss/damage occurred: _____
(DD/MM/YYYY)

Location (including city and country) where the loss/damage occurred:_____

Were the police informed? ☐ Yes ☐ No

*If yes, please provide the police report or number:*_____

Please attach a copy of the report.

Have you submitted a claim for compensation for lost baggage or personal effects from your transport provider? ☐ Yes

Please attach a copy of any report or correspondence provided by the transport provider.

If you have not submitted a claim for compensation from your transport provider you will need to do this before submitting a claim to us.

Claim Details

Item	Date Purchased (DD/MM/YYYY)	Personal Effect?	Business/Company Owned?	Replacement Amount
Less amount paid in compensation by either the transport provider or any other insurance				
Total Amount Claimed				

I. RENTAL VEHICLE EXCESS WAIVER CLAIM

Does your claim relate to your personal vehicle or a rental vehicle? ☐ Personal ☐ Rental

If your claim relates to a rental vehicle, was it rented from a licenced rental agency? ☐ Yes ☐ No

Please provide details of the accident/damage/theft:

If your claim relates to your personal vehicle, did you hire a similar vehicle? ☐ Yes ☐ No

If yes, please provide further details including the cost of hire:.

Vehicle Excess: _____

Towage Fees incurred (if applicable): _____

Are your towage fees covered under a roadside assistance agreement, motor policy or your rental agreement? ☐ Yes ☐ No

Total Amount Claimed: _____

J. PERSONAL LIABILITY

1. Date incident happened: _____ (DD/MM/YYYY) 2. Time of incident: _____
3. Location of incident: _____
4. Did the incident result in: ☐ Third Party bodily injury ☐ Third Party property damage ☐ Both
5. Description of the circumstances leading up to the incident together with details of any bodily injury or property damage suffered by the third party:

6. Has a claim been made against you by a third party? ☐ Yes ☐ No
   If yes, please provide details:

7. Details of the third party(s) involved:

   Name: _____ Name: _____

   Address: _____ Address: _____

   Post Code: _____ Post Code: _____

   Contact Number: _____ Contact Number: _____

   Contact email: _____ Contact email: _____

8. Details of any witnesses to the incident:

   Name: _____ Name: _____

   Address: _____ Address: _____

   Post Code: _____ Post Code: _____

   Contact Number: _____ Contact Number: _____

   Contact email: _____ Contact email: _____

9. Details of any other insurance held by the Insured Person covering personal liability:

   Name and address of the insurance company: _____

   Policy number: _____ Will a claim be made on this insurance policy? ☐ Yes ☐ No

K. PLEASE USE THIS SECTION TO PROVIDE FURTHER INFORMATION IF NEEDED

PAYMENT DETAILS

Electronic Funds Transfer

Please provide details for the payment of this claim in the event that this claim is deemed payable by Berkshire Hathaway Specialty Insurance (BHSI). In such an event this claim shall be payable to the relevant insured person only in accordance to terms and conditions of the relevant policy.

Payee Name (name as per bank account): _____

Name of Bank: _____

Bank Address: _____

Swift Code: _____ IBAN: _____

Bank Code: _____ Branch Code: _____

Account Number: _____

Notification of payment will be sent to the email address stated in the "Your Information" section of this form. If you require notification of payment to be sent to another address please provide details below:

Email: _____

Please note that all payments will be made directly to the Policyholder unless otherwise agreed. All payments will be made in the currency of the policy.

Important Notice:

BHSI shall (i) be discharged from all liability under this claim and (ii) not be liable for any and all losses incurred by you, as a result of you providing BHSI with an inaccurate bank account number under this section for the payment of this claim.

DECLARATION, AUTHORIZATION AND DATA PRIVACY CONSENT

I hereby declare that to the best of my knowledge and belief, the particulars and information as declared by me are true and complete in every respect and are made without reservation of any kind.

I understand, and if I am submitting this form on behalf of another individual, I have ensured that the individual understands, that if I/he/she make any false or fraudulent statements, or withhold material facts whatsoever, the policy may be void and I/he/she shall forfeit any or all rights to recover therein.

With respect to personal information collected pursuant to this claims submission, I agree and consent, and if I am submitting or releasing personal information relating to another individual, I represent and warrant that (A) I have the authority on behalf of that individual to provide or release that information and consent to the BHSIC Recipients; (B) I have informed the individual about the purposes for which his/her personal information is collected, used and disclosed as well as the parties to whom such personal information may be disclosed by the BHSIC Recipients, as set out below; and (C) the individual agrees and consents that the BHSIC Recipients may collect, use and process my/his/her personal information pursuant to this Data Privacy Consent.

I, on behalf of myself or that individual, authorise any hospital doctor or other person who has attended or examined me/him/her, to furnish to Berkshire Hathaway Specialty Insurance Company (BHSIC) and other BHSIC related bodies corporate, affiliates and branches, BHSIC's authorised representatives, service providers, professional advisors and business partners (BHSIC Recipients), any and all information relating to any illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A copy of this authorisation shall be considered as effective and valid as the original.

(a) The personal information collected pursuant to any claims submission (or otherwise provided during the course of the claim process, including by way of call recordings) may be collected, used and disclosed by BHSIC to:
   - (i) administer and process the insurance claim;
   - (ii) investigate, assess, adjust and make a decision the claim;
   - (iii) administer my/his/her insurance policy (including pursuing recovery from reinsurers or other third parties)
   - (iv) handle disputes and complaints;
   - (v) compile claims history of the policyholder and/or claimants for the purpose of fraud investigation, detection and management in present and future claims;
   - (vi) respond to requests for information from public and governmental/regulatory authorities, statutory boards, and for audit, compliance, investigation and inspection purposes;
   - (vii) respond to requests from the policyholder;
   - (viii) carry out due diligence or other screening activities (including background checks) in accordance with legal or regulatory obligations or risk management procedures that may be required by law or that may have been put in place by BHSIC;
   - (ix) comply with legal or regulatory obligations and BHSIC internal policies, and
   - (x) for other purposes stated in BHSIC's Privacy Policy Statement.

(b) BHSIC may transfer the personal information to the following (whether located in Singapore, Hong Kong, Macau or elsewhere) for the purposes identified in (a) above:
   - (i) third parties providing relevant services pertaining to the administration of my/his/her policy (including reinsurers) and processing of my/his/her claim;
   - (ii) BHSIC's agents;
   - (iii) brokers, my/his/her authorized agents or representatives or next-of-kin;
   - (iv) the policyholder;
   - (v) legal process participants and their advisors;
   - (vi) governmental/regulatory authorities, industry associations, courts, other alternative dispute resolution forums;
   - (vii) any financial institutions for the purpose of administering my/his/her claim and obtaining policy payments;
   - (viii) loss adjustors, assessors, third party administrators, emergency providers, legal services providers, retailers, medical providers and travel carriers, internal and external auditors;
   - (ix) any member of BHSIC group (for all the purposes stated in (a) above) in any country; or
   - (x) other parties referred to in BHSIC's Privacy Policy Statement.

Note: *The full version of BHSIC's Privacy Policy Statement can be found at https://bhspecialty.com/privacy-policy/privacy-policy-singapore/.*

Name of Employee	Your Position
Signature of Employee	Policyholder Company's Name & Affix Company's Stamp
Date (DD/MM/YYYY)	Name & Signature of Policyholder's Authorized Signatory