

IMPORTANT INSTRUCTIONS:

1. Please contact the emergency hotline indicated in the policy contract in case you need emergency assistance while traveling.
2. For claims processing, all necessary documents have to be submitted. The company reserves the right to request additional documents as deemed necessary.
3. Submission of required documents does not guarantee approval of your claim. The submitted documents will be reviewed and evaluated, subject to the limits, terms and conditions of your existing Travel Policy.
4. This form together with the official receipt(s) must be submitted within a period of not more than 90 days from the date of the assistance. Failure of the claimant to submit necessary documents within the given period shall be deemed an abandonment of the claim.

SECTION I – INSURED’S INFORMATION

Name of Insured				Policy Number	
Birthdate (mm/dd/yyyy)		Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
Contact No./Mobile No.			Email Address		
Complete Address of Insured	No./St.	Barangay/District	Town/City	Province	Zip Code

SECTION II – CLAIMANT’S INFORMATION

Name of Claimant			Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Complete Address of Claimant	No./St.	Barangay/District	Town/City	Province	Zip Code
Birthdate (mm/dd/yyyy)			Relationship to the insured		
Contact No./Mobile No.			Email Address		

SECTION III – TYPE OF LOSS

PLEASE CHECK PARTICULAR TYPE OF LOSS

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Medical Expenses | <input type="checkbox"/> Repatriation Expenses | <input type="checkbox"/> Trip Cancellation | <input type="checkbox"/> Trip Curtailment |
| <input type="checkbox"/> Flight Delay | <input type="checkbox"/> Luggage and Personal Effects | <input type="checkbox"/> Luggage Delay | <input type="checkbox"/> Personal Accident |
| <input type="checkbox"/> Others (Please specify): | | | |

SECTION IV – DETAILS OF INJURY OR SICKNESS

Nature and Condition of Injury or Sickness	
Place/Address where injury or sickness occurred	
Hospitalization/Consultation Dates	
Name of Hospital	Attending Physician

FRAUD WARNING:

Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who represents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim.



Travel Insurance

General Claim Form

v.2025_12

Hospital Address	No./St.	Barangay/District	Town/City	Province	Zip Code
Contact No./Mobile No.			Email Address		
Date/s when patient had any prior treatment of the same illness					

SECTION V – ATTENDING PHYSICIAN STATEMENT *(if applicable)*

<input type="checkbox"/> Out-Patient <input type="checkbox"/> In-Patient	Complete Diagnosis of Medical Condition:
Admission Date	
Discharged Date	
Date of Consultation	
Do you consider this consultation/hospitalization as a continuous treatment for a chronic disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the patient have any other diseases or infirmity that is affecting his/her present condition?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, please describe:	<hr/> Attending Physician's Signature over printed name

SECTION VI – OFFICIAL RECEIPT SUBMITTED

Official Receipt (O.R.) Number	Description	Amount
Name of Payee as it should appear on the check		If Payee is not the insured, indicate relationship to the insured
TOTAL AMOUNT CLAIMED		
For processing of payment on approved claims, please indicate bank details for a Direct Credit to your nominated Bank Account.		
Bank Account Name		
Bank Complete Address		
Bank Account Number	Account Type	

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Other Documents Submitted:	FOR FLIGHT DELAY <input type="checkbox"/> Certificate from the Airline <input type="checkbox"/> Incident Report from Client
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FOR EVALUATION PURPOSES (DO NOT FILL-UP)			
Reference File Number	Claim Outcome:	Approved	Denied
Evaluation	Processed by: _____ Signature over Printed Name		
	Approved by: _____ Signature over Printed Name		

List of Acceptable IDs					
ID1	Passport	ID10	GSIS e-Card/UMID	ID19	Department of Social Welfare and Development (DSWD) Certification
ID2	Driver's License	ID11	SSS	ID20	Integrated Bar of the Philippines (IBP) ID
ID3	PRC ID	ID12	Senior Citizen Card	ID21	Company ID
ID4	NBI Clearance	ID13	Overseas Workers Welfare Administration (OWWA) ID	ID22	Student's ID
ID5	Police Clearance	ID14	OFW ID	ID23	National ID
ID6	Postal ID	ID15	Seaman's Book	ID24	SEC Certificate of Registration
ID7	Voter's ID	ID16	Alien/Immigrant Certification of Registration	ID25	Business Registration Certificate
ID8	TIN	ID17	Gov't Office/GOCC ID	ID26	PhilHealth ID
ID9	Barangay Certification	ID18	Certification from National Council for the Welfare of Disabled Persons (NCWDP)	ID27	Others (subject to review/validation by Oona Insurance Corporation)

All IDs presented should be within their validity period, clearly readable, untampered, and consistent with the information provided in the relevant application document(s). **Oona Insurance** may require additional supporting documents as deemed necessary.

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