CO-OPERATORS GENERAL INSURANCE

TRAVEL CLAIM FORM

1. THE INSURED		
Policy Number:	**Claim Number:**	
Name of Insured:		
Policy Holder Details:		
Address:		
Parish:	**Occupation:**	
Business:	**Telephone Number:**	

2. PERSONAL LUGGAGE		
Name of Owner:		
House/Lot #:	**Road/Avenue:**	
Area in PA:	**Parish Area:**	**Parish:**
Date of Loss or Damage:	**Time of Loss or Damage:**	
Circumstances of loss or damage:		
Date advised to Police:		
Address of Police Station		
House/Lot #:	**Road/Avenue:**	
Area in PA:	**Parish Area:**	**Parish:**
If luggage or money is insured under any other Policy, please state the name of address of insurers		
Name of Insurer:		
House/Lot #:	**Road/Avenue:**	
Area in PA:	**Parish Area:**	**Parish:**

3. DETAILS OF LUGGAGE

No. of Articles	Description	When Purchased	Where Purchased	Cost Paid	Amount Claimed

4.	**PERSONAL ACCIDENT/LOSS OF DEPOSITS**	
Name of Injured person:		
Date of Birth:	**Occupation:**	
House/Lot #:	**Road/Avenue:**	
Area in PA:	**Parish Area:**	**Parish:**
Description of Accident &/or illness:		
Date of Accident:	**Time:**	**a.m./p.m.**
Nature of Injury:		
Name of Doctor who attended:		
House/Lot #:	**Road/Avenue:**	
Area in PA:	**Parish Area:**	**Parish:**
Has a similar injury been sustained before? Yes ( ) No ( ). If so, when?		
Name of Usual Doctor:		
House/Lot #:	**Road/Avenue:**	
Area in PA:	**Parish Area:**	**Parish:**
During what period was the injured person totally disabled from attending to any part of his occupation or profession?		
From:_____20___ To_____20___		
If total disablement continues, a medical certificate will be required from the injured person's usual Doctor.		
FOR CLAIMS FOR 'LOSS OF DEPOSITS' PLEASE STATE		
	HOTEL/ACCOMODATION COSTS	**TRANSPORT**
1. Amount of Deposit		
2. Percentage returned by carrier		
Net amount claimed		
I declare that the particulars given on this form are to the best of my knowledge, true and complete.		
Date:_____ Signature of Insured:_____		

5.	MEDICAL AND OTHER EXPENSES	
Name of Person concerned:		**Date of Birth:**
House/Lot#	**Road/Avenue:**	
Area in PA:	**Parish Area:**	**Parish:**
Nature of injury or illness:		**Date:**
Cause of injury or illness:		
Name of Doctor who attended:		
House/Lot#	**Road/Avenue:**	
Area in PA:	**Parish Area:**	**Parish:**
If the cause was illness, has the person concerned previously suffered similar illness? Yes ( ) No ( ). If so, when?		
Details of expenses claimed.		
Receipts and documents supporting this claim are to be sent with this form.		
I declare that the particulars given on this form are, to the best of my knowledge, true and complete. **Date:**_____ **Signature of Insured:**_____		