AIG
AIG損保

Overseas Travel Insurance Claim Form

For medical expense

To AIG General Insurance Co., Ltd.

Date

- I hereby file a claim for insurance benefits on the basis of the insurance contract with AIG General Insurance Co., Ltd. by attaching the relevant documents.
- In case I receive more than the amount of loss that is stipulated by this policy or other insurance policies that against the same loss or expense, I immediately refund the balance to AIG General Insurance Co., Ltd. and other insurers. If AIG General Insurance Co., Ltd. and other insurers specify how to refund, I will follow their instructions.
- In case I have other insurance policies that cover this loss, I agree that AIG General Insurance Co., Ltd. claim other insurance companies the amount that exceeds the portion of the loss to be paid by AIG General Insurance Co., Ltd.

1 Insured (Traveler)/Claimant

Certificate/Policy No.			ID No. if the policy is corporate contract			
Insured	Name		Daytime Telephone No.			
			Email Address			
	Address in Japan	〒 −		Sex	Male / Female	
	Office		Date of Birth		Age	
Not necessary when the insured files a claim						
Claimant	Name		Daytime Telephone No.			
			Email Address			
	Address	〒 −				

2 Other Insurance Information

● Please fill in below : Circle all that apply.

Other overseas travel insurance policy that would cover this loss.	Name of company		Policy No.	
Please circle all credit cards you have.	JCB / MitsuiSumitomoVISA / UC / DC / Master / SuMi TRUST CLUB(CITI) / NICOS / ORICO / MUFG / JACCS / LIFE APLUS / CF / VIEW / Diners / Amex / JAL / ANA / UA / OMC / AEON / VISA Executive / VISA Amitie / JCB Nexus・Grande / EPOS / Rakuten / Other credit card with Overseas Travel Insurance 【Card Name: 】			

3 Sickness/Injury/Accident

Date of Injury		Sickness	Date of first consultation		Country	
			Date first symptom appeared		City	
Details of accident or sickness						

1) Have you ever got treatment for same symptoms?	No / Yes ▶	Hospital	
		Treatment Period	
		Was the symptom fully cured?	No / Yes
2) Do you take any medicine regularly?	No / Yes ▶	Name of medicine	

Power of attorney

I hereby authorize ① hospital, physician, ② ( ) to file a claim and receive the payment.

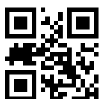
Signature :

4 Bank Account Information

Name of Bank		Name of Branch		For JapanPostBank (9900)	
Futsu・Sogo / Toza		Branch No.	Account No.	PassbookCode	PassbookNumber
				1 0	
Account Holder					

Continues to the reverse side.

代理店受付日	年 月 日	保険会社受付日	



5 Attending Physician's Statement

● To be completed by physician only.

患者氏名 Patient's name		患者生年月日 Patient's Date of Birth	/ /
症状が現れた日 Date of illness (first symptom) or injury	/ /	他の疾病の影響はございますか Describe any other disease affecting present condition.	
初診日 Date of first consultation.	/ /	妊娠による疾病ですか Is condition due to pregnancy?	No Yes
患者は以前に同様の症状を訴えたことがありますか Has patient ever had same or similar symptoms?	No Yes	いつ頃でしょうか If yes, give approx. date.	/ /
		以前の症状で実際に治療を受けましたか If yes, did patient receive any treatment for prior symptoms by any doctor?	No Yes
治療の期間 Period of your treatment	外来 Out patient / 往診 Home visit / 入院 Confinement	自 From / / 至 To / /	
傷病名および経過 State diagnosis or nature of illness or injury.			
他の機関で治療を受けたならば、その住所、病院名 Name & address of facility where services were rendered for this illness or injury.		転医日 Date of transfer	/ /
治癒日 Date of Recovery	/ /	後遺障害の有無(ケガの場合) Prognosis (in case of injury)	なし Good / あり Poor
職業看護師の付添が必要でしたか Was professional nursing required?	No Yes	自 From / / 至 To / /	
病院名・住所 Hospital name & address	電話 Tel (– –)		
担当医署名 Signature of Attending physician		日付 Date	/ /

6 Authorization

I hereby make a claim for insurance benefits, by confirming the accuracy of the contents hereof and also by agreeing to the matters mentioned below. A photocopy of this form shall be considered as effective and valid as the original.

I hereby authorize any hospital, physician , or other person who has attended or examined the insured, to furnish to AIG General Insurance Co., Ltd., or its authorized representative, any and all information with respect to any sickness or injury, medical history, consultation, prescriptions or treatment as well as copies of all hospital or medical records.

I hereby agree that AIG General Insurance Co., Ltd. makes inquiries or discloses my personal information among other insurers and mutual benefit associations on any matters in connection with the insurance policy/policies and/or the insurance claim relating to myself.

I hereby agree that AIG General Insurance Co., Ltd. shall use personal information on the claim documents which were submitted with regard to this claim for the following purpose:

(1) Underwriting, renewal and maintenance of insurance, and payment of claims and benefits;
(2) Notification and provision of services and products handled by our group and affiliated companies, and maintenance of their contracts;
(3) Provision of information concerning our business, and for enhancement of products, services and operations;
(4) Activities to achieve appropriate and effective operations and transactions with customers;
(5) Other operations related to the above.

I hereby agree that AIG General Insurance Co., Ltd. shall, in addition to the case where AIG General Insurance Co., Ltd. have consent from the said personnel, provide personal information to third parties in the following cases:

(1) Entrusting our operations to third parties (including our agents), to the extent necessary for achievement of such purposes;
(2) Reinsurance arrangement;
(3) If deemed necessary for sound management of the insurance system, including registration of the details of the "Policy" under a system established and managed by the insurance industry;
(4) Other cases in which such provision is deemed necessary due to laws, regulations or ordinances.

However, pursuant to laws, regulations, or ordinances, any special private information (sensitive information) such as healthcare records shall only be used for the appropriate management of operations, and only to the extent necessary for such purpose. Furthermore, specific personal information, including Individual Numbers ("My Number") shall not be used for any purpose other than those permitted by the "Act on the Use of Numbers to Identify a Specific Individual in Administrative Procedures".

I hereby agree that the necessary information (content of contracts such as policy limits, information related to the claims such as loss amount, information related to paid indemnities) is furnished and used in order to recover the loss amount which exceeds the share of AIG General Insurance Co., Ltd. from other insurers as follows;

(1) AIG General Insurance Co., Ltd. furnishes the information to other insurers and obtains the information from the insurers and uses it.
(2) The other insurers furnish the information to AIG General Insurance Co., Ltd, and obtain the information from AIG General Insurance Co., Ltd.

Signature of Insured : ______________________ Date : ______________

AIG損保