

## Claims Declaration Form Individual Travel Insurance

### Instructions

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1. Complete the form in all parts with print and legibly.
2. Submit evidence of your claim according to coverage.
3. Attach a copy of your personal identity document.

### Part I – Insured Claimant Information

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Policy No. \_\_\_\_\_ Certificate No. \_\_\_\_\_

Name of the Titled Insured \_\_\_\_\_

Name of the Insured Claimant \_\_\_\_\_

Personal Identity No. (Passport) \_\_\_\_\_ Occupation \_\_\_\_\_

Complete Address \_\_\_\_\_ Residence Phone \_\_\_\_\_

City Address \_\_\_\_\_ Country Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail \_\_\_\_\_

### Part II – Coverage Claimed

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- |  |   |
|--|---|
| <input type="checkbox"/> Accidental Death During Travel          | <input type="checkbox"/> Journey Delay                            |
| <input type="checkbox"/> Organ Loss by Accident                  | <input type="checkbox"/> Journey Cancellation or Interruption     |
| <input type="checkbox"/> Medical Expenses for Accident / Illness | <input type="checkbox"/> Loss of Luggage                          |
| <input type="checkbox"/> Emergency Dental Expenses               | <input type="checkbox"/> Luggage Delay                            |
| <input type="checkbox"/> Medicines                               | <input type="checkbox"/> Protected Purchase (theft with violence) |
| <input type="checkbox"/> Emergency Medical Transfer              | <input type="checkbox"/> Personal Property                        |
| <input type="checkbox"/> Repatriation of Mortal Remains          | <input type="checkbox"/> Forced Burglary to Resident Home         |
| <input type="checkbox"/> Daily Income for Hospitalization        | <input type="checkbox"/> Other: _____                             |

Part III – Travel Details

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Stat Date of Trip \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (Month/Day/Year)      Return Date of Trip \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (Month/Day/Year)  
Country Origin \_\_\_\_\_ Country Destination \_\_\_\_\_

Part IV – Claim Details

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Occurrence Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (Month/Day/Year)      Place where the incident occurred \_\_\_\_\_  
Describe how the incident occurred

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Claim related to COVID-19

Claimed Amount \_\_\_\_\_ Currency \_\_\_\_\_

Authorization

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I hereby declare and represent that the information provided is complete and accurate, and I assume full responsibility for its truthfulness. I authorize Chubb Seguros Panamá S.A. to verify and request any information it deems relevant for the handling, review, and assessment of this claim.

I further acknowledge and agree that my personal data and, where necessary, sensitive data (including health-related information), may be processed by Chubb Seguros Panamá S.A. for the purpose of handling and assessing the insurance claim and for complying with applicable legal and contractual obligations. I authorize their potential transfer to affiliated entities and/or contracted third parties, subject to appropriate confidentiality and security measures, including transfers outside the Republic of Panama. In accordance with Law 81 of 2019 on Personal Data Protection, I have the right to exercise my rights of access, rectification, cancellation, opposition, and portability of my personal data. The procedure to exercise these rights, the data retention criteria, the existence of automated decision-making, and the contact details of the Data Protection Officer are detailed in the Privacy Policy available on the company's website.

\_\_\_\_\_  
Insured Claimant Signature

\_\_\_\_\_  
Date (Month/Day/Year)