Assuria VERZEKERINGEN

How to file a claim

Dear Insured:

Please read this document carefully.

Our main priority is to provide you, while travelling, with the best quality of service and give you the peace of mind needed, when emergency medical treatment is required by you or your family members.

For Emergency Assistance contact Redbridge Assist

In case of an unforeseen event, a medical emergency or any question, incident or claim, contact us immediately by calling the telephone numbers listed below to offer the best service available in the area of your location. You can also write to us at: service@redbridgeassist.com
In the event of a life- threatening medical emergency, go to the nearest Emergency Center for the necessary medical assistance and contact **REDBRIDGE** within the next 48 hours to avoid incurring excessive costs.

Redbridge Assist 24 hours per/day 7 days per/week:

For medical emergencies and assistance with your medical care, please contact:
for US / Canada (Toll Free):
- **+1.866.537.1145**
- **+1.800.785.4154**

Worldwide (collect):
- **+1.305.537.1145**
- **+1.305.463.9696**

E-mail: service@redbridgeassist.com
Whatsapp: 1.786.653.3717

Claims need to be submitted at Assuria.
Checklist when contacting Assuria:

1. Claim form completed by the policyholder/claimant.
2. ALL original bills relating to the claim, plus proof of travel (e.g., email confirmations of trip, booking invoices, tickets.).
3. Attending physician statement (for medical claims)

For more information please contact your agent or visit us at:

SURINAME
ASSURIA SCHADEVERZEKERING N.V.
Paramaribo
Recolaan 17
P: 473400
E: trias.verzekeringen@assuria.sr
WhatsApp: +597 8277799

GUYANA
ASSURIA GENERAL (GY) INC.
Georgetown
Lot 133 Church Street
South Cummingsburg
P: 226-7052
E: guyana@assuria.sr

Assuria VERZEKERINGEN

TRIAS WORLD Claim Form

To help us process your claim quickly, please follow these guidelines:

1. Complete a separate claim form for each claim and for each insured person.
2. If you are submitting a claim following an accident or injury, please complete in full Sections A, B & G.
3. If you are submitting a claim for a non-medical incident or personal luggage loss, please complete Sections A, (C - E as appropriate) & G.
4. If you are submitting a Personal Accident claim, please complete Sections A, F & G.
5. Whenever you or a other insured person receive medical treatment, the Claimsreport Service Provider TRIAS World should be completed by the medical provider. This report must always be submitted when submitting a claim following an accident or injury.
6. Please send this fully completed form to trias.verzekeringen@assuria.sr, along with ALL bills relating to the claim, plus proof of travel (e.g., email confirmations of trip, booking invoices, tickets.)
7. Please send completed claim form and supporting documents to:

   SURINAME

   Paramaribo:

   Recolaan 17, Paramaribo

   P: 473400 ext.: 375, 763, 499

   Nickerie:

   R.P. Bharosstraat 68, Nw Nickerie

   P: 597-231911, 597-231757

   GUYANA

   Assuria General (GY):

   Lot 133 Church Street

   South Cummingsburg, Georgetown

   P: 226-7052, 226-7074

8. All claims MUST be submitted to Assuria within 90 days from the incident/ illness.
9. Contact details Redbridge:
   For Emergency Assistance contact REDBRIDGE ASSIST
   USA / Canada Toll Free: +1.866.537.1145/ +1.800.785.4154 or Worldwide collect +1.305.537.1145/ +1.305.463.9696.
   NOTIFY REDBRIDGE WITHIN 48 HOURS FOR ALL MEDICAL EMERGENCIES & IN ALL CASES INVOLVING REPATRIATION.
   FAILURE TO DO SO MAY RESULT IN A 50% COPAY OR DENIAL OF THE CLAIM .

A. DETAILS OF INSURED

TYPE OF POLICY

❑ Trias Single Trip Policy number :

❑ Trias Multi Trip Policy number :

POLICY HOLDER DETAILS

Name (Last, First, MI):

Date of birth :

Policy Number / Reference Number:

Address :

Postal Code / Zip : Phone Number :

E-mail : Fax :

Policy Currency : ❑ US$

CLAIMANT DETAILS

Name (Last, First, MI):

Address :

Postal Code / Zip : Phone Number :

Occupation :

Was journey : ❑ Holiday ❑ Business

Dates of journey : From: To:

Is the claim the result of an accident? ❑ Yes ❑ No

PLEASE LIST DOCUMENTS ENCLOSED:

B. MEDICAL EXPENSES & HOSPITAL BENEFIT

Nature of illness/injury:

Date and time of illness/injury:

Please confirm where the illness/injury took place:

Please provide a detailed description of how the illness/injury occurred:

Name and address of doctor(s) and/or hospital(s) from which treatment was received:

Details of claimant's personal family physician / doctor :

Name (Last, First, MI):

Address:

Phone Number :

Fax Number :

Email :

If treatment was given in hospital as an inpatient please confirm the dates:

Was the Emergency Assistance Company contacted: ❑ Yes ❑ No

If no, please state the reason why not:

Was the insured Person pregnant: ❑ Yes ❑ No

If yes, how many weeks?

If the Insured Person has suffered illness, has he/she suffered from this before: ❑ Yes ❑ No

If yes, please provide details:

Does the Insured Person have Private Medical Insurance: ❑ Yes ❑ No

If so, please provide the insurance carrier details including name, address and policy number:

C. MISSED DEPARTURE/TRAVEL DELAY

Reason for missed departure/travel delay:

MISSED DEPARTURE/TRAVEL DELAY

Point of departure: Point of Missed Connection:

Method of transport being used to arrive at departure point:

Please confirm how you recommenced trip:

Amount claimed:

D. BAGGAGE, PERSONAL EFFECTS, MONEY & DOCUMENTS

Date of loss or damage: Time:

Please provide a detailed description of how the loss/damage occurred, including the location:

Please confirm when the loss/damage was reported and to which authority (e.g., police/airline/tour operator/hotel, etc.), including complete address and reference:

If the loss relates to travellers cheques/ cheques / cash / credit, bankers or charge card please confirm when the issuer was notified:

- If the loss occurred at the airport or on the aircraft we will require the Property Irregularity Report and this should be sent with this claim form.
- Please provide proof of the original purchase/ownership, i.e., receipts, bank/credit card statements, photographs, packaging, instructions manuals, valuations.
- Please note that we may make a deduction on the claim if proof of purchase is not provided and/or if wear-and-tear is applicable.
- If items have already been replaced please send the replacement invoice or receipt.

ITEM DETAILS

Full description of item 1:

Where purchased and date purchased:

Price paid: Cost now: Amount claimed:

Full description of item 2:

Where purchased and date purchased:

Price paid: Cost now: Amount claimed:

IMPORTANT

In the event of a personal baggage loss, all incidents MUST be reported to the local police within 24 hours. An incident number and loss report must be obtained and submitted to Assuria Schade Verzekering N.V.

Please provide details of any other insurance policy that you have that may contribute to this loss, e.g., household insurance, private medical insurance, personal travel insurance, credit card insurance, etc.:

Name of Insurer: Policy Number:

Correspondence Address:

E. LOSS OF PASSPORT

Please confirm where the passport was lost:

Please provide details of the expenses incurred to replace the passport, including receipts:

F. PERSONAL ACCIDENT

When did the injury, or (in the event of a fatality) death occur?

Please detail the nature of the loss or how the death occurred:

Was the injury or cause of death as a result of natural causes?: ❑ Yes ❑ No

If yes, please give details:

G. DECLARATION

For Data Protection Purposes I/We acknowledge that any personal data secured from me/us as a result of this claim will be held and processed for insurance administration and claims investigation. For this purpose, the information may also be passed to selected third parties and reinsurers.

I/We consent to your processing of sensitive data about me/us and other persons who may be insured under the contract.

I/We understand that all personal data I/We supply must be accurate and I/We have the specific consent of those other persons insured to disclose their personal data.

I/We consent to the inquiry of information from other insurers, Credit and other information Agencies to check the answers we have provided and will authorize the release of such information.

I/We declare that on settlement I/We transfer all rights of subrogation and recovery to the Insurer and or/their Loss Adjuster.
Please note that we have rights to salvage and we will exercise these rights where applicable.

I/We declare that, to the best of our knowledge, the information submitted in this form is correct and complete.

Insured Person

Name :

Signature :

Date :

Policy Holder

Name :

Signature :

Date :

SPECIFICATION OF INVOICES SUBMITTED

	Name of health care provider/business	Specialism/ Type of business	Date of treatment/Date of purchase	Currency	Amount Paid
1.					
2.					
3.					
4.					
5.					
6.					
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