Regent Insurance Company Ltd.
Travel Division
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Regent is an Authorised Financial Services Provider, FAIS Licence Number: 25511

CLAIMS ROLES AND RESPONSIBILITIES OF REGENT AND EUROP ASSISTANCE

1. REGENT

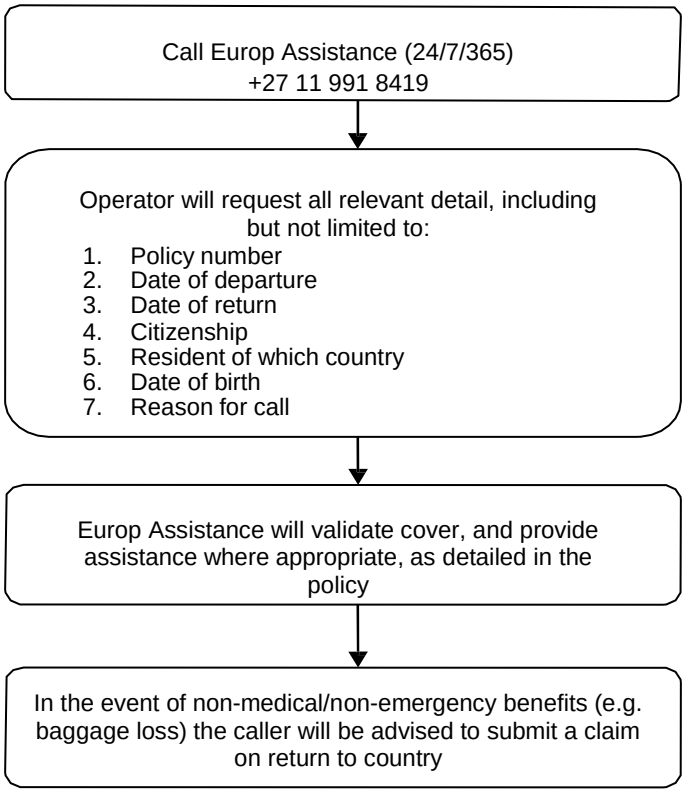
Regent Insurance Company is the underwriter of your policy. Regent agrees to provide insurance on the basis set out in the Policy Wording, up to the limit of liability reflected in the Schedule of Benefits (refer to your certificate). The final decision to settle or repudiate/reject a claim remains with Regent.

2. EUROP ASSISTANCE SOUTH AFRICA

Europ Assistance S.A. is the claims co-ordination company authorized by Regent to assist in the management and control of all Regents' travel insurance claims. The mandate includes the following services:

1. Whilst you are on an international journey:
   - Medical assistance
   - Authorisation/guarantee of payments to medical service providers
   - In-hospital monitoring
   - 24-hour assistance telephone line
   - Return of mortal remains
   - Accompanying family members (assistance & return)
2. After you have returned from an international journey
   - Receipt, assessment and settlement of all travel insurance claims
   - Liaise with Regent on any claims where validation of cover is required
   - All claims are assessed in accordance with the Regent terms and conditions

CALL FLOW FOR CLAIMS:



Claims Procedures: A completed claim form that has been signed by the insured person, copies of airline tickets, copy of passport, letters from airlines, and other items that may be required must be submitted to Europ Assistance.

TRAVEL INSURANCE CLAIM FORM

(To be completed on behalf of the insured where the insured is under 18 or where power of attorney has been granted)

Please note that a policy excess is usually applicable in respect of each claim and in respect of each person. Read your policy wording carefully to ensure you are claiming for a covered event, and that you have complied with all the conditions of the wording. All information provided must be accurate and true.

If you have any queries concerning your claim, please feel free to contact Europ Assistance on Tel + 27 (0) 11 991 8419 or Fax 27 (0) 11 388 3544 or email assist@europassistance.co.za. If your wish to send the claim form and documents by mail we recommend Postnet Courier to our physical address (Valley View Office Park, 680 Joseph Lister Street, Constantia Kloof, Ext 31, South Africa)

1. INSURED'S DETAILS

Policy no. _____

Full names _____

Title _____ Date of birth _____

Residential address _____

_____

Postal address _____

Telephone no. H _____ W _____ C _____

F _____ Email _____

Which country are you a citizen of? _____

Please specify if there is any other country where you have residence status? _____

2. TRAVEL DETAILS

Are you still on your trip (Please indicate "N for No" and "Y for Yes") _____

If yes, what is your current address? _____

_____

What are your contact details where you are presently? _____

Full names of travel companion or person you are staying with _____

Contact details of travel companion or person you are staying with _____

Full names of family member in South Africa _____

Contact details of family member in South Africa _____

3. BANKING DETAILS

Name of bank _____

Branch _____ Branch code _____

Type of account _____

Account no. _____

Full names of accountholder _____

For the purpose of EFT payments, we require a copy of a cancellation cheque or a copy of your bank statement. All claims are payable to the insured person, or the insured person's legal guardian only.

SECTION 1

1. MEDICAL CLAIM: INCIDENT DETAILS

1. Please provide us with the following
   1.1. Medical report stating
      i. Diagnosis, date of first consultation, treatment provided, cause of the illness/injury
      ii. If you were declared not fit to travel: Stating that you were not fit to fly, and the medical reason
   1.2. Copy of driver's license of the driver of the vehicle if M.V.A. (public driver's permit if taxi driver)
   1.3. The medical questionnaire attached
   1.4. All bills or invoices
2. Incident date (date of accident or date you became ill) _____
3. Did you contact Europ Assistance before about this event or claim? (Please indicate "N for No" and "Y for Yes") _____
   If yes, please specify when and where? _____
4. Did you consult a medical practitioner? (Please indicate "N for No" and "Y for Yes") _____
   a) If yes, give full names of Practitioner _____
   b) Telephone no. of Practitioner W _____ C _____
5. Were you hospitalised as an inpatient? (Please indicate "N for No" and "Y for Yes") _____
   a) If yes, please indicate date of authorisation obtained from Europ Assistance _____
6. Please give a detailed diagnosis

7. Describe the circumstances surrounding your claim, including all relevant dates and places (add pages if necessary)

8. Have you ever received treatment for this or a related illness? (Please indicate "N for No" and "Y for Yes") _____
   a) If yes, please supply a medical report from your treating doctor prior to commencing your journey

2. MEDICAL AID AND OR OTHER INSURANCE DETAILS

1. Do you have other travel or private medical insurance that might cover this trip? (Please indicate "N for No" and "Y for Yes") _____

2. If yes, please complete the following
   a) Full name of Insurer _____
   b) Policy or membership no. _____
3. Medical Aid Details
   a) Full name of Medical Aid _____
   b) Membership no. _____
4. Did you pay for the airline ticket with a credit card? (Please indicate "N for No" and "Y for Yes") _____
   a) If yes, which card? _____
   b) Card no. _____
5. Did you purchase optional insurance from your bank? (Please indicate "N for No" and "Y for Yes") _____
   a) If yes, what was the date of purchase? _____

3. COSTS YOU HAVE ALREADY PAID

Please include all receipts in relation to the costs you are claiming below. Our normal practice is to settle claims direct to the insured in Rands. When converting your claims we use the rate as obtained from ABSA Bank on the date of payment.

Nature of expense	Who did you pay?	Foreign amount	Rand amount
			R
			R
			R
			R
			R
			R
		Total amount claimed	R

4. OUSTANDING ACCOUNTS DETAILS

Please provide information regarding the hospital, treating doctors and other service providers who have treated you or who are currently treating you, who you have not already paid in full (It is important to notify us of all providers/doctors that have been involved in your treatment, in order for us to ensure we receive all outstanding accounts within 90 days after your return.)

Name of service provider	Telephone no.	Nature of expense	Known or anticipated amount
			R
			R
			R
			R
			R
			R

ACCESS TO MEDICAL REPORTS

Before signifying your consent to our obtaining a medical report as well as information and or documentation from your medical aid, you should read this note carefully as it sets out your rights and the procedure for dealing with such reports.

You do not have to give your consent but, should this be your decision, we may not be able to proceed with your claim. If you consent, you have the right to advise the doctor and or medical aid in writing, that you wish to see the report, documentation and or information before it is sent to us. If you exercise that right, the doctor and or medical aid cannot then send us the report until either

i) you have seen it and have consented to its being sent to us, or
i) you have allowed 21 days to pass without the doctor and or medical aid having received any further communication concerning arrangements for you to see the report.

It would be your responsibility to make arrangements with your doctor and or medical aid for inspection of any report he or she prepares, or information and or documentation so supplied by your medical aid. Of course, the quicker you act the quicker we can proceed with your claim. If you ask for a copy of the report, information and or documentation, the doctor and or medical aid can charge a reasonable fee to cover the costs of supplying it,

i) Whether or not you say you wish to see the report, information and or documentation before it is sent to us you should also have the right to ask your doctor and or medical aid to let you see copies of same, provided you ask within six months after it is supplied to us.
ii) If you see any report, information and or documentation in accordance with your rights, the doctor and or medical aid will need your consent before he or she can send it to us. Alternatively, you can contact the doctor and or medical aid asking him or her to amend any part of the report, information and or documentation which you consider to be incorrect or misleading. If you and your doctor and or medical aid cannot agree on the fact set out in the report, information and or documentation you have the right to ask him or her to attach a statement of your views on any part of the report, information and or documentation about which you and he or she are not in agreement and which the doctor and or medical aid is not prepared to alter.
iii) The doctor and or medical aid is not obliged to let you see any part of the report if
    a) in his or her opinion, that would be likely to cause serious harm to your physical or mental health or that of others, or
    b) it would indicate the doctor's and or medical aid's intention in respect of you, or
    c) disclosure would be likely to reveal information about, or the identity of, another person who has supplied information about you, unless that person has consented, or the information relates to, or has been supplied by, a health professional involved in caring for you. In such cases, the doctor and or medical aid must notify you accordingly and will be able to send only the remainder of the report, information and or documentation. If it is the whole report which is affected, he or she must not send it to us unless you give your consent.

MEDICAL QUESTIONNAIRE

Please note: Medical information provided will be strictly confidential and will only be used to assess the validity of your medical claims.

1. GENERAL PRACTITIONER'S DETAILS

Full names of General Practitioner _____

Telephone no. W _____ C _____

Period of time seen _____

2. MEDICAL DEATAILS

2.1. Please complete the table of Specialists you have seen in the past 2 years

Full names	Specialist	Treatment received

2.2. Please list your current medication

2.3. Please give a description of previous surgery done

Date	Description of surgery

2.4. Have you ever been treated for any of the following conditions? (Please indicate "N for No" and "Y for Yes" for all the questions)

a) Heart disease, e.g. high blood pressure, angina, heart attack, bypass, thrombosis _____
b) Lung disease, e.g. TB, asthma, pneumonia, pneumothorax (burst lung), blood clots _____
c) Neurological disease, e.g. stroke, fits, blackouts, paralysis, concussion _____
d) Bone and joint problems, e.g. gout, slipped disc, arthritis _____
e) Hormone problems, e.g. diabetes, thyroid disease, hormone deficiencies _____
f) Urological problems, e.g. bladder or kidney problems _____
g) Mental disorders, e.g. depression, anxiety, drug abuse _____
h) Cancer or tumour of any kind? _____
i) Any other significant medical problem? _____

2.5. If the answers to any of the above questions is "Yes", supply details below

Questions	Date	Details

DECLARATION AND CONSENT

I, _____(full names of claimant) declare that the above details are correct to the best of my knowledge and that failure to divulge any information may invalidate my claim.

I hereby authorise any hospital, physician or other person who has attended or examined me to furnish Regent and or Europ Assistance, or its authorised representative all information with respect to any injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records.

I consent to my insurers obtaining a medical report from my specialist or general practitioner as well as information and/or documentation from my medical aid, as well as all other relevant information and or documentation required to process the claim. I have been informed of my rights (see Annexure A), and I agree that a copy of this consent shall have the validity of the original.

I understand that I may refuse this permission, but that this will render my claim null and void. I understand that the information provided in relation to this claim may be shared with other insurers for the purpose of dealing with this claim.

I further declare that I am aware that any misrepresentation and/or non-disclosure in respect of information provided herein shall render my claim null and void.

I hereby declare that I HAVE / HAVE NOT (please delete whichever is not applicable) claimed from a travel insurance policy during the past 24 months

i) please provide details of any claims incurred
   a) Name of insurer _____
   b) Type of claim _____

ii) If claimant is signing on behalf of the insured, please provide
   c) Full name _____
   d) Relationship _____

Signed at _____

_____
Signature

SECTION 2

1. DEATH OR PERSONAL ACCIDENT DETAILS

1. Are you claiming for death or permanent disablement? _____

2. Please give a description of the accident

_____

_____

_____

_____

3. The following documentation is required in order to substantiate your claim

a) Certified copies of the abridged and final death certificate

b) Certified copy of the post mortem report

c) Certified copy of the full inquest report including witness statements pertaining thereto

d) Police accident report if the death was due to a motor vehicle accident

e) The police station and reference number if death is the subject of a criminal investigation

f) Copies of any newspaper clippings, eye-witness statements or incident reports that may be available with reference to the accident

SECTION 4

1. CANCELLATION, COMPASSIONATE EMERGENCY EVACUATION, MISSED CONNECTION, NATURAL DISASTER AND TRAVEL SUPPLIER INSOLVENCY DETAILS

1. Please provide the following

a) Medical report stating

i. Diagnosis, date of first consultation, treatment provided, cause of the illness/injury

ii. Stating that you were not fit to fly, and the medical reason for this

b) Death certificate of the person that is the cause of the claim (including when this person was first diagnosed)

c) Proof of deposits not recoverable (letters from the airlines, tour operators, etc. confirming original payment amount, payment date, and refund amount)

d) If your claim is a result of an illness/injury, please complete the medical questionnaire attached

e) Carrier report if caused by carrier, stating the reason for incoming flight delay, original arrival time, and new arrival time (missed connection)

2. What are you claiming for? (Please indicate “N for No” and “Y for Yes” for all the questions)

a) Cancellation expenses _____

b) Missed connection expenses _____

c) Compassionate emergency repatriation expenses _____

d) Natural disaster cover _____

e) Travel supplier insolvency cover _____

3. Please provide full details of the claim including the date of incident

_____

_____

_____

_____

Nature of expense	Date authorised by us	Original amount paid	Refund amount	Amount claimed
		R	R	R
		R	R	R
		R	R	R
		R	R	R
		R	R	R
		R	R	R

SECTION 5

1. BAGGAGE, CASH AND TRAVEL DOCUMENTS

Please note: A single item limit is applicable in terms of the conditions of the policy

1. Please provide the following
   a) Original purchase invoices
   b) Boarding passes
   c) Police report obtained in country where the loss occurred
   d) Carrier irregularity report if loss was caused by carrier

Description of item	Date purchase	Amount claimed

2. How many bags did you check-in? _____
3. Please state the weight of the checked-in bags _____
4. Did you pool your bags with any other travellers? (Please indicate "N for No" and "Y for Yes") _____
5. Describe how the delay, loss, theft or damage occurred

_____

_____

_____

_____

6. Name of airline, police station or country where you reported the incident _____
7. Date incident was reported _____

IMPORTANT: Please attach a letter from the airline confirming the loss, and whether any compensation was paid

8. Have you received compensation from the Air Carrier? (Please indicate "N for No" and "Y for Yes") _____
   a) If yes, please state the amount compensated _____
   b) If not reported, give reason why not

_____

_____

_____

9. Are you the sole owner of the goods lost, stolen or damaged? (Please indicate "N for No" and "Y for Yes") _____
10. Were the items on you personally, a safety deposit box, or unattended? _____
11. Name of short-term insurer (All Risk Insurer) _____
12. Policy number _____
13. Are you claiming from the above named short -term insurer? (Please indicate "N for No" and "Y for Yes") _____

SECTION 6 and 7

1. TRAVEL DELAY DETAILS

1. Please provide the following
   a) Letter from the carrier confirming the delay and the reason for the delay
   b) Original purchase invoices for essential items purchased
2. What was the reason for the delay? _____
3. Date of delay _____ Time of delay _____
4. Duration of delay _____
5. Departure time of new flight _____ Departure time of original flight _____
6. Did you receive any compensation or alternative travel arrangements from the carrier? (Please indicate "N for No" and "Y for Yes") _____
   a) If yes, please state the amount compensated _____

Nature of expense	**Date of purchase**	**Amount claimed**
		R
		R
	Total amount claimed	R

SECTION 8

1. PERSONAL LIABILITY DETAILS

1. Please provide the following
   a) Copies of all correspondence, summons, notice of intent to take legal action, etc
   b) Police reports
2. Please describe in full the incident that is the cause of the claim

_____

_____

_____

_____

3. Date of incident _____ Time of incident _____
4. If the claim is as a result of you causing injury to another person, please state the relationship between yourself and the claimant _____
5. If the claim is as a result of you causing loss or damage to property, please confirm who the legal owner is of the property, and state your relationship with the owner _____
6. Total amount claimed _____

SECTION 9

1. HIJACK OF PUBLIC TRANSPORT

Please provide the following

1. Written confirmation from the airline carrier confirming the incident
2. Please describe in full the incident that is the cause of the claim

_____

_____

_____

_____

3. Date of incident _____ Time of incident _____

SECTION 10

1. KIDNAP AND WRONFUL DETENTION

Please provide the following

1. A police report outlining the details of the incident
2. Proof of any payments paid out
3. Date of incident _____ Time of incident _____

SECTION 11

1. RENTAL CAR EXCESS

We require:
1. Detailed account of the circumstances surrounding the event, including photographs and video evidence (if applicable)
2. Full details of any witnesses and written statements where available.
3. Detailed account of the circumstances that led to the accident.
4. Appropriate written police report

COSTS YOU HAVE ALREADY PAID

Please include all receipts in relation to the costs you are claiming below. Our normal practice is to settle claims direct to the insured in Rands. When converting your claims we use the rate as obtained from ABSA Bank on the date of payment.

Nature of expense	Who did you pay?	Foreign amount	Rand amount
			R
			R
			R
			R
			R
			R
		Total amount claimed	R