

Personal Effects and Money Claim Form

Ace American Insurance Company

P.O. Box 15417
Wilmington, DE 19850
800-336-0627 OR 302-476-6194
FAX – 302-476-6154
DIANE.BASA@ACE-INA.COM

THANK YOU FOR NOTIFYING US OF YOUR CLAIM
PLEASE COMPLETE **ALL** QUESTIONS - IF ANY QUESTION IS NOT APPLICABLE PLEASE STATE
AN/A≡

Name of Insured: University of California
Policy No: ADDN04223810

Full Name of Covered Person: (Mr., Mrs., Miss, Ms)	Date of Birth:
Full Address:	Zip/Postal Code:
Tel No. (Business):	(Home):
E-Mail Address:	

TRAVEL DETAILS
Type of Travel: Business/Holiday:
Please give date of loss/damage/theft:
In which country did the loss/damage/theft occur:
Please give full details of the loss/damage/theft:
To whom was the loss/damage/theft reported? (Please see notes below and provide a copy of this report)
On which date was the loss/damage/theft reported?
If article(s) lost/stolen: What steps were taken regarding recovery of the article(s)? Please provide any written evidence
If article(s) damaged: Please supply estimates for cost of repairs or a letter from a reputable dealer confirming irreparably damaged. Please supply receipts - if not available please supply replacement estimates/invoices.

Is any property lost/damaged/stolen insured by any other company? YES/NO

If YES, please supply name, address, telephone number and policy number:

Please supply name, address, telephone number and policy number of homeowners/household contents insurers:

Have you had any previous claims on this type of insurance? YES/NO

If YES, please give full details with relevant dates:

PAYMENT INFORMATION *Please complete either Option #1 or Option # 2*

μ **OPTION #1 Payment to EMPLOYEE - Please indicate where you wish the payment to be sent and in what currency.**

μ **Your home address as listed above** **Direct deposit to your bank account**

Name on account: _____ Account #: _____

Bank Name: _____ Swift Code: _____

Bank Address: _____ Currency: _____

μ **OPTION #2 - Payment to a Provider, e.g. hospital, physician**

Please complete Provider's name and address in Section E of this Claim Form

μ **OPTION #3 Payment to the Employer**

Employer's Name: _____

Employer's Address: _____

Notes:

1. All losses should be reported to the local police and a report obtained. This should be forwarded to ACE American Insurance Company.
2. All losses or damaged property which occurred while in the custody of an airline should be reported and a Property Irregularity Report Form obtained. This should be forwarded to ACE American Insurance Company together with the ticket stubs.

PLEASE ENSURE THE APARTICULARS OF CLAIM≅ FORM IS FULLY COMPLETED AND ATTACHED.

DECLARATION

I declare that all the information given is to the best of my knowledge and belief, full, true and correct.

Signed: _____

Date: _____

PLEASE ENSURE (/)

- You have completed ALL relevant questions on this claim form.
- You have enclosed all requested information/documentation and the Particulars of Claim form.
- You have signed this claim form.

As failure to do so will result in delay in handling your claim.

Please return the completed claim forms together with any enclosures to your Insurance Broker or to ACE American Insurance Company at the address shown.

Thank you for fully completing this form.

**Mail to: ACE American Insurance Company
Claims Department
P.O. Box 15417
Wilmington, DE 19850
Telephone No: 800.336.0627 or 302.476.6194
Fax No. 302.476.6154
Diane.Basa@ace-ina.com**

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PARTICULARS OF CLAIM					
Full description of each item of property lost, damaged or stolen	State to whom property belonged	Date of Purchase	Original Cost Price		Receipts/ Replacement Estimates Attached (/)

TOTAL SUM CLAIMED

PLEASE ENSURE YOU PROVIDE RECEIPTS IF POSSIBLE OR REPLACEMENT ESTIMATES FROM A REPUTABLE RETAILER FOR ITEMS \$150.00 OR OVER