



CLAIMS FORM FOR GROUP TRAVEL INSURANCE

Claimant's Name : _____	
Claimant's Address: _____	
Phone No.(Mobile): _____	Phone No.(Res) : _____
E-mail ID: _____	
Policy Start Date : dd/mm/yyyy	Policy End Date : dd/mm/yyyy
In what capacity are you making this claim ? _____	

HOSPITALIZATION EXPENSES FOR INJURY

Provide name, address & telephone number of Hospital / Clinic:

Treating Doctor's Name & Qualifications:

Treating Doctor's Telephone Number: (O) _____ (M) _____

Room / Ward / Bed Number:

Dates of treatment: From DD / MM / YYYY To: DD / MM / YYYY

Date of onset of symptoms: DD / MM / YYYY

Attending Doctor's Report

Date doctor contacted: DD / MM / YYYY Time: HH: MM

Nature of Ailment:

State diagnosis and nature of treatment provided:

When did patient's symptoms first appear?

Describe any other disease or infirmity affecting present condition:

Was the ailment due to Pregnancy: Yes / No

Was the ailment aggravated due to any pre-existing condition? Yes / No

If yes, please give details:

Medical Evacuation

Can the patient be evacuated back to the Republic of India? Yes / No

Medical Doctor's Signature and Date:

MEDICAL TREATMENT EXPENSES DETAILS

Sr. No.	Details of medical treatment/ medical evacuation/expenses	Date	Expenses in Foreign Currency / INR
			Total:

Documents to be submitted in support of the claim:

1. Medical reports and discharge summary issued by the Hospital furnishing the name of the Insured, period of treatment, details of treatment rendered.
2. Bills / receipts for:
 - a. Charges paid towards Hospital accommodation, nursing facilities and other medical services rendered;
 - b. Fees paid to the Medical Practitioner, special nursing charges, etc.
 - c. Charges incurred towards any and all test and / or examinations rendered in connection with the treatment.
 - d. Charges incurred towards medicines or drugs purchased from outside duly supported by the prescriptions of the Medical Practitioner attending on the Insured.

In respect of all claims payable hereunder, the Company may effect settlement either in the form of cashless treatment facility or by reimbursement of the amount of claim to the Insured, at its sole discretion. Cashless treatment facility cannot be demanded by the Insured as a matter of right.

REPATRIATION OF REMAINS:

Cause / Circumstances of death:

Date of death of insured: DD / MM / YYYY

Details of expenses incurred for repatriation of Remains / Funeral:

Sr. No.	Details of treatment/expenses	Date	Expenses in Foreign Currency / INR
			Total:

Documents to be submitted in support of the claim:

1. Photocopy of the death certificate providing the details of the place, date and time, and the circumstances and cause of the death (photocopy of the postmortem certificate wherever required by the Third Party Administrator), issued by the appropriate authority where the contingency has arisen.
2. Proof for expenses incurred towards disposal of the mortal remains.
3. In case of transportation of the body of the deceased to the Country of Residence of the Insured, the receipt for expenses incurred towards preparation and packing of the mortal remains of the deceased and also for the air transportation of the mortal remains of the deceased to the Country of Residence of the Insured.

☐ CHECKED-IN BAGGAGE LOSS /DELAY:

Describe when & where the Loss / Delay took place:

State the extent of Delay / Loss:

Place of Delay / Loss:

Name the common carrier:

No. of Hours of bag delay:

Flight Details:

1. Flight No.: From: To:
2. Flight No.: From: To:

Actual Date & Time of Arrival of flight at Port: DD / MM / YYYY HH:MM

Actual Date & Time when Bags were delivered: DD / MM / YYYY HH:MM

Had the common carrier been notified at the time of loss? Yes / No

Property Irregularity Report (PIR) number from Airline/ Common Carrier:

Details of compensation received from carrier:

Sr. No.	Item Purchased / Items Lost	Date of Purchase	Cost in Foreign Currency (In INR for loss claim)

Total:
Compensation From Airlines:
Net Amount:

Documents to be submitted in support of the claim for Checked-in Baggage Loss:

1. Statement of claim furnishing the details of items contained in the Checked-In Baggage.
2. Property irregularity report issued by the Common Carrier.
3. Voucher of the Common Carrier for the compensation paid for the non-delivery / short delivery of the Checked-In Baggage.

4. Copies of correspondence exchanged, if any, with the Common Carrier in connection with the non-delivery / short delivery of the Checked-In Baggage.

In case of compensation from the Common Carrier having been received after payment of the claim by the Company hereunder, the Insured shall repay to the Company such amount in excess of his / her loss after taking into account the amount of claim received from the Company and at that received from the Common Carrier.

In case the undelivered Checked-In Baggage is subsequently traced by the Common Carrier and offered for delivery to the Insured, the Insured shall take delivery of the Checked-In Baggage and refund the amount paid by the Company hereunder. In case of delivery of part of the Checked-In Baggage, the amount paid by the Company attributable to such Checked-In Baggage shall be refunded by the Insured to the Company.

Documents to be submitted in support of the claim Checked-in Baggage Delay:

1. Property irregularity report stating the scheduled time of delivery and actual time of delivery of the Checked-In Baggage issued by the Common Carrier;
2. Voucher of the Common Carrier for the compensation paid for the delay in delivery of the Checked-In Baggage;
3. Copies of correspondence exchanged, if any, with the Common Carrier in connection with the delay in delivery of the Checked-In Baggage.

PERSONAL ACCIDENT

Please state circumstances of accident i.e. how, when, where it took place:

Nature of Injury:

State diagnosis and nature of treatment / surgery under taken:

Provide name, address & telephone number of Hospital / Clinic:

Treating Doctor's Name & Qualifications:

Treating Doctor's Telephone Number: (O) _____ (M) _____

Room / Ward / Bed Number:

Dates of treatment: From DD / MM / YYYY To: DD / MM / YYYY

Attending Doctor's Report

Date doctor contacted: DD / MM / YYYY Time: HH: MM

Nature of Ailment:

State diagnosis and nature of treatment provided:

Describe any other disease or infirmity affecting present condition

Was the accident due to Pregnancy: Yes / No

Was the accident due to any pre-existing condition: Yes / No

If yes, please give details:

Can the patient be evacuated back to the Republic of India? Yes / No

Loss Incurred (Please tick):

Death

Permanent Total Disability: (Details) _____

Permanent Partial Disability: (Details)_____

Medical Doctor's Signature and Date:

Documents to be submitted in support of the claim:

1. Medical reports giving the details of the Accident, nature of Injury and the extent of disability.
2. In case of death of the Insured, death certificate issued by the Medical Practitioner who attended on the Insured.
3. Postmortem certificate to be produced if required by the Third Party Administrator. Police report in original in case the Accident shall have taken place in a public place or premises.

TRIP CANCELLATION AND INTERRUPTION :

Trip Cancelled / Trip interrupted Also claiming for Trip Regained

Reason for Trip Cancellation /Interruption: _____

Please detail out the above reason for trip cancellation / interruption (how, where, when and reason for the same):

Trip Cancellation / Interruption date: DD / MM / YYYY

Original Travel Dates: From: DD / MM / YYYY To: DD / MM / YYYY

Person Affected and Relationship with the Insured: (If not the Insured, please also provide address and contact details)_____

Details of Losses / Expenses Incurred:

Sr. No.	Loss / Expenses Details	Amount
		Total:

Documents to be submitted in support of the claim:

1. In case of cancellation of the Trip either in the City of Residence of the Insured or any other intermediate place forming part of the Trip by the Common Carrier solely resulting from contingencies namely Earthquake, Storm, Flood, inundation, cyclone, tempest & Terrorism, fog (if specifically covered) duly completed claims form to be accompanied by:
 - a. Confirmation of cancellation of the Trip from the Common Carrier detailing the circumstances of cancellation;
 - b. Original used air ticket indicating the cost the ticket and receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the Trip the cancellation charges retained;

- c. Original bill and a receipt / letter obtained from the hotel and / or guest house and / or any other paid residential accommodation (available for fee) indicating the amount paid for the accommodation, the refund given and the cancellation charges retained, wherever such accommodation has been arranged at the place of cancellation of the Trip;
 - d. Used air ticket in original for return journey from the place of cancellation to the City of Residence of the Insured which indicate the cost of the tickets together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip.

- 2. In case the cancellation of the Trip shall result because of personal contingencies covered hereunder or a decision taken at the instance of the Insured arising out of the contingencies namely Earthquake, Storm, Flood, inundation, cyclone, tempest & Terrorism, fog (if specifically covered) the duly completed claims form to be accompanied by:
 - a. A declaration from the Insured furnishing the circumstances that compelled him / her to cancel the Trip;
 - b. Medical evidence as may be required by the Third Party Administrator in case of the cancellation of the Trip arising out of personal contingencies of the Insured or his / her Immediate Family;
 - c. Receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the Trip indicating the cancellation charges retained;
 - d. Receipt / letter obtained from the for the hotel and / or guest house and / or any other residential accommodation (available for a fee) indicating the cancellation charges retained, wherever such accommodation has been arranged at the place of cancellation of the Trip;
 - e. Used air ticket or boarding pass in original for return journey from the place of cancellation to the City of Residence of the Insured together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip.

- 3. In case the cancellation charges either for the Trip or part of it or in relation to the accommodation in a hotel / guest house / other residential accommodation is waived to the advantage of the Insured subsequent to any settlement of claim under this Benefit, the Insured shall forthwith return the sum paid by the Company to the extent of such waiver.

□ **TRIP DELAY :**

Reason for Trip Delay:

Please detail out the reason for trip delay (how, where, when, what was lost and reason for the same):

Original Travel Dates: From: DD / MM / YYYY To: DD / MM / YYYY

Trip delayed on: DD / MM / YYYY

Person Affected and Relationship with the Insured: (If not the Insured, please also provide address and contact details) _____

Details of Expenses Incurred:

Sr. No.	Loss / Expenses Details	Amount
		Total:

Documents to be submitted in support of the claim:

In case of delay of the Trip, at any places forming part of the Trip, by the Common Carrier solely resulting from contingencies namely earthquake, storm, flood, inundation, cyclone, tempest & terrorism, fog (if specifically covered) duly completed claims form to be accompanied by, confirmation of delay of the Trip from the Common Carrier detailing the circumstances of delay.

□ MISSED(FLIGHT) CONNECTION :

Original Travel Schedule: (Please give date and time of all flights, mentioning the original and actual arrival and departure times. Please also mention the name of carriers and flight numbers)

Which flight was delayed causing a missed connection?

Reason for delay of the flight:

Details of expenses due to Missed Connection:

Sr. No.	Expenses	Amount
		Total:

Documents to be submitted in support of the claim:

1. The confirmation from the Common Carrier of the delayed flight as to the expected time of arrival and the actual time of arrival at the port of delay together with the reasons for delay.
2. Unused ticket for the ongoing flight (Missed Flight) with an endorsement of the Common Carrier of cancellation of the same.
3. Certificate from the Common Carrier of the Missed Flight that the fare for the part of the Trip covered by the Missed Flight is forfeited in full or in part together with the amount of forfeiture.
4. Original used ticket obtained afresh towards the alternative flight for the part of the Trip covered by the Missed Flight indicating the amount paid as fare.

In the event of the forfeited amount by the Common Carrier for the Missed Flight being refunded / returned to the Insured, subsequent to any payment under this section, the Insured shall return the amount so refunded in full.

COMPASSIONATE VISIT :

Person Hospitalised: Insured Family Member

Name of the person hospitalized (if not the insured):

Relationship with the insured:

Provide name, address & telephone number of Hospital / Clinic:

Treating Doctor's Name & Qualifications:

Treating Doctor's Telephone Number: (O) (M)

Room / Ward / Bed Number:

Dates of hospitalisation: From DD / MM / YYYY To: DD / MM / YYYY

Date of onset of symptoms: DD / MM / YYYY

Attending Doctor's Report

Date doctor contacted: DD / MM / YYYY Time: HH : MM

Nature of Ailment:

State diagnosis and nature of treatment provided:

When did patient's symptoms first appear?

Describe any other disease or infirmity affecting present condition:

Was the ailment due to Pregnancy: Yes / No

Was the ailment aggravated due to any pre-existing condition? Yes / No

If yes, please give details:

Can the patient be evacuated back to the Republic of India? Yes / No

Estimated time the patient would continue to be in the hospital?

Medical Doctor's Signature and Date:

EXPENSES DETAILS

Sr. No.	Details of expenses	Date	Expenses in Foreign Currency / INR
			Total:

Documents to be submitted in support of the claim:

1. A certificate from the Medical Practitioner recommending the presence in the form of special assistance to be rendered by a member of the Family or near relative during the entire period of Hospitalization. Certificate to also specify the minimum period of Hospitalization.

2. Discharge summary of the Hospital furnishing details – date of admission, date of discharge, and the presence of the member of the Family or near relative on all days of Hospitalization.
3. Original ticket used for the travel to and fro by the member of the Family or near relative.