CLAIM FORM

TRAVEL INSURANCE

General Information
(To be filled in for all types of claim)

Policy Particulars:

Policy No. _____

Endt. No. (if any) _____

Insured's Name _____

Insured's Contact No. _____

Loss Particulars:

Date of Loss _____

Type of Loss (Please Tick)

☐ Personal Accident (Death & Disability) ☐ Medical Expenses ☐ Medical Evacuation

☐ Death Repatriation ☐ Emergency Dental Care ☐ Total Loss of Checked–In Baggage

☐ Loss of Passport ☐ Baggage Delay ☐ Flight Delay ☐ Trip Cancellation & Curtailment

☐ Loss of Credit Card ☐ Emergency Return Home ☐ Travel & Stay Over of One Immediate Family Member

☐ Return of Dependent Children ☐ Dispatch of Medication ☐ Personal Liability

Please attach the following documents with all types of claims:

1. Original Policy.
2. Original Endorsement (if any).
3. Air Tickets and any other traveling documents proving actual travel period.
4. Photo Copy of Passport.

Claim Form

Travel Insurance

Personal Accident (Death or Permanent Disability)

1. Name of Loss Sustaining Person _____
2. Date of Loss _____
3. Place of Loss _____
4. Circumstances of Loss {attach extra sheet(s), if required}
   _____
   _____
5. Cause of Death (for death claims only)
   _____
   _____
6. Cause and Extent of Disability (for disability claims only)
   _____
   _____
7. Name, Address and Telephone Nos. of Hospital/ Clinic where treatment was given
   _____
8. Name of Attending Doctor _____
9. Details of Any Third Party Involved in the Accident
   _____
10. Total Amount Claimed _____

Please attach the following documents in Original for claim verification and assessment:

1. Death Certificate issued by Competent and Authorized Entity stating cause of death (for death claims only).
2. Disability Certificate issued by Competent & Authorized Entity stating cause and extent of disability (for Permanent Disability claims only).
3. Police Report stating cause of loss.
4. Medical Treatment Document

Claim Form

Travel Insurance

Medical Expenses Claim – Sickness or Injury

1. Name of Loss Sustaining Person _____

2. Date of Loss _____

3. Place of Loss _____

4. Circumstances of Loss {for injury related claims only}{attach extra sheet(s), if required}

_____

_____

5. Name, Address and Telephone Nos. of Hospital/ Clinic where treatment was given

_____

6. Name of Attending Doctor _____

7. Nature of Ailment _____

_____

8. Was the Ailment/ Injury aggravated due to a pre-existing condition? Please give details

_____

_____

9. Details of Treatment Received & Expenses Incurred {attach extra sheet(s), if required}

_____

10. Details of Any Third Party Involved in the Accident (for Injury related claims only)

_____

11. Total Amount Claimed _____

Please attach the following documents in Original for claim verification and assessment:

1. Original Paid Medical Bills/ Invoices/ Receipts
2. Attending Physician's Prescriptions
3. Attending Physician's Case Summary
4. Discharge Summary (for hospitalization & ER admission)
5. Police Report (for Injury related claims only)

Claim Form

Travel Insurance

Medical Expenses Claim – Dental Treatment:

1. Name of Loss Sustaining Person _____

2. Date of Loss _____

3. Place of Loss _____

4. Circumstances of Loss{attach extra sheet(s), if required}

_____

_____

5. Name, Address and Telephone Nos. of Hospital/ Clinic where treatment was given

_____

6. Name of Attending Doctor _____

7. Nature of Ailment _____

_____

8. Was the Ailment/ Injury aggravated due to a pre-existing condition? Please give details

_____

_____

9. Details of Treatment Received & Expenses Incurred {attach extra sheet(s), if required}

_____

_____

10. Total Amount Claimed _____

Please attach the following documents in Original for claim verification and assessment:

1. Medical Bills/ Invoices/ Receipts.
2. Attending Physician's Prescriptions.
3. Tooth/teeth treated.
4. Treatment performed.

Claim Form

Travel Insurance

Repatriation of Mortal Remains

1. Name of Insured Person _____
2. Date of Death _____
3. Place of Death _____
4. Circumstances of Loss (attach extra sheet(s), if required

   _____

   _____

5. Cause of Death for (for death claims only)

   _____

   _____

6. Name, Address and Telephone Nos. of Hospital/Clinic where treatment was given

   _____

8. Name of Attending Doctor _____
9. Total Amount Claimed _____

Please attach the following document in original for claim verification and assessment:

1. Death certificate.
2. Physician's statement stating cause of death.
3. Original bills/receipts for expenses incurred.

Claim Form

Travel Insurance

Total Loss of Checked - in - baggage

1. Name of Insured Person _____
2. Date of Loss _____
3. Place of Loss _____
4. Detail of Loss (When & Where) attach extra sheet(s), if required

   _____

   _____

5. Name, Address and Telephone Nos. of Airline.

   _____

6. Total Amount Claimed _____

Please attach the following document in original for claim verification and assessment:

1. Property Irregularity Report Issued by the carrier.
2. Proof of ownership of items valued in excess of USD,100/-
3. Letter from the carrier stating compensation received for lost baggage.

Claim Form

Travel Insurance

Delay of Checked - in - baggage

1. Name of Insured Person _____
2. Date of Baggage Delay_____
3. Place of Loss Baggage Delay_____
4. Detail of Baggage Delay (When & Where) attach extra sheet(s), if required

   _____

   _____

5. Name, Address and Telephone Nos. of Airline.

   _____

6. Total Amount Claimed _____

Please attach the following document in original for claim verification and assessment:

1. Property Irregularity Report stating the date and time of baggage arrival.
2. Original bills/receipt of emergency items purchased.

Claim Form

Travel Insurance

Flight Delay (Excess First 12 Hours)

1. Name of Insured Person _____
2. Date of Delayed_____
3. Place of Delayed_____
4. Reason for Delaying
   _____

   _____
5. Name, Address and Telephone Nos. of Airline.

   _____
6. Total Amount Claimed _____

Please attach the following document in original for claim verification and assessment:

1. PNR (Passenger Name & Record) where should has the narration of Flight Delayed.
2. List of Items purchased.
3. Original bills/receipts of emergency items purchased.

Claim Form

Travel Insurance

Loss of Passport

1. Name of Insured Person _____
2. Date of Loss _____
3. Place of Loss _____
4. Detail of Loss (When & Where) attach extra sheet(s), if required

   _____

   _____

   _____

   _____

5. Total Amount Claimed _____

Please attach the following document in original for claim verification and assessment:

1. Police report obtained with 24 hours of becoming aware of the theft/loss.
2. Bills/receipts of expenses incurred in obtaining fresh or duplicate passport.

Claim Form

Travel Insurance

Trip Cancellation & Curtailment

1. Name of Loss Sustaining Person _____
2. Date of Loss _____
3. Place of Loss _____
4. Circumstances of Loss {attach extra sheet(s), if required}
   _____
5. Total Amount Claimed _____

Please attach the following documents in Original for claim verification and assessment:

1. Original tickets of the traveling companion(if applicable)
2. Original bills/invoices of reasonable additional expenses incurred and/ or proof of cancellation charges levied by the carriers.

Claim Form

Travel Insurance

Travel and Stay Over of One Immediate Family Member

1. Name of Loss Sustaining Person _____

2. Date of Loss _____

3. Place of Loss _____

4. Circumstances of Loss {for injury related claims only}{attach extra sheet(s), if required}

_____

_____

5. Name, Address and Telephone Nos. of Hospital/ Clinic where treatment was given

_____

6. Name of Attending Doctor _____

7. Nature of Ailment _____

_____

8. Was the Ailment/ Injury aggravated due to a pre-existing condition? Please give details

_____

_____

9. Details of Treatment Received & Expenses Incurred {attach extra sheet(s), if required}

_____

_____

10. Details of Any Third Party Involved in the Accident (for Injury related claims only)

_____

11. Total Amount Claimed _____

Please attach the following documents in Original for claim verification and assessment:

1. Medical reports, statement from Attending Physician.
2. Doctor's statement indication the need for an attendant