

OVERSEAS TRAVEL INSURANCE CLAIM FORM

1. This form must be signed and dated in all applicable sections.
2. The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the company, nor a waiver of any of the terms and conditions of the insurance contract
3. Please answer all questions completely. In case of insufficient space, please attach an additional sheet.
4. Please attach all Original bills & receipts pertaining to your claim.

Insurance Cert. No./Card No

Is the claim intimated Yes _____ If No kindly confirm reason _____

DETAILS OF PATIENT/INSURED PERSON

	(First name)	(Middle name)	(Last name)
Name of the Insured	<input type="text"/>		
Name of the Employee	<input type="text"/>		
Name of the Claimant	<input type="text"/>		
Phone Nos Overseas	<input type="text"/>		
Permanent Address	<input type="text"/>		
City	<input type="text"/>	State <input type="text"/>	PIN <input type="text"/>
Phone (O)	<input type="text"/>	Phone (R) <input type="text"/>	Mobile <input type="text"/>
Fax	<input type="text"/>	E-mail <input type="text"/>	
Date of Birth	<input type="text"/>	Passport No.	<input type="text"/>
Date of Departure	<input type="text"/>	Flight No.	<input type="text"/>
Date of Arrival	<input type="text"/>	Flight No.	<input type="text"/>

DETAILS OF INSURED'S INDIAN BANK ACCOUNT (Submission of Cancelled Blank Cheque Leaf with Payee Name Printed OR Copy of the First page of the Bank Passbook is Mandatory)

Name of the Account Holder (As per Bank Account)

Account No (As appearing in the cheque book)

Bank Name

Branch Name & Address

Account Type Saving Current Cash Credit

MICR No. IFSC Code:

PAN Cheque / DD Payable Details:

DECLARATION

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize Bajaj Allianz General Insurance Company Limited, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim

Date:

Place:

Signature of the Insured

PLEASE COMPLETE THE SECTION RELEVANT TO YOUR CLAIM

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> MEDICAL EXPENSES | <input type="checkbox"/> DENTAL TREATMENT | <input type="checkbox"/> MEDICAL EVACUATION | <input type="checkbox"/> HIV |
| <input type="checkbox"/> MATERNITY AND BABY COVER | <input type="checkbox"/> MENTAL ILLNESS AND ALCOHOL RELATED DISORDER | <input type="checkbox"/> CANCER SCREENING | <input type="checkbox"/> HOSPITALIZATION DAILY ALLOWANCE |
| <input type="checkbox"/> CANCER SCREENING AND MAMMOGRAPHY | <input type="checkbox"/> MEDICAL REPATRIATION | <input type="checkbox"/> PRE EXISTING ILLNESS | <input type="checkbox"/> PA COVER IN INDIA |

Name & Address of overseas consulting physician

City State PIN

Phone (O) Phone (R) Mobile

Fax E-mail

Have you ever been treated for this illness before in India:

If yes, provide name & address of consulted physician

City State PIN

Phone (O) Phone (R) Mobile

Fax E-mail

Provide name & address of your family physician:

City State PIN

Phone (O) Phone (R) Mobile

Fax E-mail

Diagnosis _____
 if sickness-state nature of diagnosis and advise when and where symptoms first occurred _____
 Kindly confirm nature of Injury: Self Inflicted Accident
 Substance Abuse/Alcohol Consumption at the time of accident Yes No
 If Accident kindly confirm how where and when it happened _____
 Kindly confirm if accident reported to Police Station Yes No (If yes Kindly attached FIR copy)
 Treatment Taken Outpatient _____ Inpatient _____
 Treatment Type- Medical - Yes No or Surgical - Yes No
 Kindly Provide name and address of diagnostic center in India where regular health checkup/investigations carried out _____
 Provide name of medicine you were taking prior to departure from India: _____
 Indicate other Travel/Health insurance coverage's, including name, address, policy number & certificate number of insurer: _____

DETAILS OF MEDICAL EXPENSES

Details of treatment	In/Out Patient		Charges (Currency)	Status of Payment
	From	To	Eg : USD / EURO	Paid/Outstanding
			Paid	
			Outstanding	
			TOTAL	

LOSS /DELAY OF CHECKED BAGGAGE

Describe when & where the loss/delay took place : _____

State the extent of Loss: _____ Name the airline: _____

1. Flight No. _____ From _____ to _____ 2. Flight No. _____ From _____ to _____

Has the airlines been notified at the time of loss? Yes No Airline Reference No. _____

Details of compensation received from airline: _____

Scheduled date/time of Arrival: hrs.

Actual date/time when bags delivered hrs. No. of Hours delayed : hrs.

Item Purchased/Lost *	Date of Purchase	Place	Cost
			TOTAL
Less Compensation received from Airline: _____			
			Net Amount

*In case of Delay, please provide details of purchases made , *In case of Loss, please provide details of items lost.

LOSS OF PASSPORT

Please provide details of the incident i.e. when, where and how it happened: _____

Details of Police Report (please attach copy): _____ No: Date: Place: _____

Details of Expense/Loss Incurred*	Date	Place	Amount
			TOTAL

TRIP DELAY

Flight No. _____ Date From _____ to _____

Scheduled date/time of Arrival: hrs.

Actual date hrs. No. of Hours delayed : hrs.

Reason for trip delay: _____

Details of Expense Incurred	Date	Place	Amount
			TOTAL

TRIP CANCELLATION/ /TRIP CURTAILMENT

Flight No. _____ Date From _____ to _____

Scheduled time of Departure: hrs. Reason for Cancellation/ /Curtaiment : _____

Details of Expense Incurred	Date	Place	Amount
Amount refunded by Common Carrier and Hotel			
		TOTAL	

PERSONAL LIABILITY

Please provide details of injury/property damaged _____

Have you received a court order, if Yes, please furnish a copy Yes No

EMERGENCY HOTEL ACCOMMODATION FOR FAMILY MEMBER/ EMERGENCY HOTEL EXTENSION

Please provide details of the emergency incident _____

Details of Expense Incurred*	Date	Place	Amount
		TOTAL	

MISSED CONNECTION

Flight No. _____ Date From _____ to _____

Actual date/time of departure hrs. No. of Hours delayed : hrs. Yes No

HIJACK

Flight No. _____ Date From _____ to _____

Scheduled date/time of Departure: hrs. Date & time of Hijack hrs.

Scheduled date/time of Arrival: hrs. Date & time of Returned hrs.

Please provide details of incident: _____

FAMILY VISIT/ COMPASSIONATE VISIT/ REPLACEMENT AND REARRANGEMENT OF STAFF/MINOR ESCORT/TUTION FEES

Kindly provide detailsof incident _____

Details of Expense/Loss Incurred*	Date	Place	Amount
		TOTAL	

BAIL BOND/LOSS OF LAPTOP/HOME BURGLARY/LOSS OF PERSONAL BELONGINGS/ /EMERGENCY CASH ADVANCE

Please provide details of the incident i.e. when, where and how it happened: _____

Details of Police Report (please attach copy): No: _____ Date: Place: _____

Details of Expense/Loss Incurred*	Date	Place	Amount
		TOTAL	

I declare that the above answers are true and correct to the best of my knowledge and that I have not withheld any relevant information which might have otherwise affected the acceptance of my application. I understand and agree that the insurance applied for will become effective only upon acceptance by the company and the premium being fully paid.

Date:

Place: _____

Signature