



WE KEEP YOU GOING

Claim No.:

For office use only

CLAIMS FORM FOR OVERSEAS TRAVEL INSURANCE

Name of insured: _____

Policy Number: _____ / _____ / _____ / _____

Policy Start Date: [D][D][M][M][Y][Y][Y][Y]

Policy End Date: [D][D][M][M][Y][Y][Y][Y]

Every claim has to be accompanied with original ticket/boarding pass or copy of the passport indicating the travel dates.

MEDICAL EXPENSES

Name, address and telephone number of hospital / clinic where treatment was given: _____

Name of treating doctor: _____

Details of ailment: _____

Cause of the ailment: _____

Was the ailment / incident caused / aggravated due to a pre-existing condition? Please give details: _____

Date of onset of ailment: [D][D][M][M][Y][Y][Y][Y]

Nature of treatment: _____

Dates of treatment: From [D][D][M][M][Y][Y][Y][Y] To [D][D][M][M][Y][Y][Y][Y]

Is medical evacuation back to the Republic of India needed? Please give detailed reasons of the ailment and reason for transportation:

Claiming also for daily allowance

Medical treatment cost details:

Sr. No.	Expense details	Amount

The above information given is just a summary report of the incident. Please attach more sheets to give details, if necessary. The claim form should be accompanied with bills / vouchers / reports / discharge summary, and they must mention the name of the person treated, type of ailment, details of individual items of medical treatment provided, and dates of treatment, along with prescriptions and original bills, and they must clearly show the medicines prescribed, price and the receipt stamp of the pharmacy. Treatment taken on different dates for separate ailments will be treated as separate medical claims, where standard deductible will apply for each claim.

Dental Treatment

Name, address and telephone number of hospital / clinic where treatment was given: _____

Name of treating dental surgeon : _____

Details of ailment: _____

Cause of the ailment: _____

Was the ailment / incident caused due to / aggravated due to a pre-existing condition? Please give details: _____

Date of onset of ailment:

Nature of treatment: _____

Dates of treatment: From To

Nature of loss: (Tick where applicable)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Fire | <input type="checkbox"/> Burglary | <input type="checkbox"/> Lightning | <input type="checkbox"/> Explosion/Implosion |
| <input type="checkbox"/> Riot, Strike & Malicious Damage | <input type="checkbox"/> Impact Damage | <input type="checkbox"/> Aircraft Damage | |
| <input type="checkbox"/> Subsidence and Landslide, including rockslide | <input type="checkbox"/> Missile Testing Operation | <input type="checkbox"/> Leakage from automatic sprinkler system | |
| <input type="checkbox"/> Bush Fire | <input type="checkbox"/> Storm, Cyclone, Typhoon, Tempest, Hurricane, Tornado, Flood & Inundation | | |
| <input type="checkbox"/> Bursting and / or overflowing of water tanks, apparatus and pipes | | | |

Exact description of Nature of loss and its causes (in case of burglary, how was forceful entry gained into the premises and who is suspected of the same) _____

Occupants of the premises at the time of Loss / by whom was it discovered: _____

Have the proper authorities (Fire Brigade & Police) been reported of the loss and by whom? Please give date of time of reporting (if not done, please give reasons): _____

Details of any other insurance cover for the property: _____

Details of Items Lost:

Sr. No.	Description of Items lost	Amount

The above information given is just a brief summary of the incident. Please attach more sheet to give details, if necessary. Please attach first information report, investigation report by the police, fire brigade report, Invoices of owned articles (if required by the company), legal opinion wherever required.

Trip Cancellation & Interruption

- | | |
|---|---|
| <input type="checkbox"/> Trip Cancelled | <input type="checkbox"/> Trip Interrupted |
|---|---|

Reason for trip cancelled / interrupted: (Tick one)

- | | | |
|---|--|--|
| <input type="checkbox"/> Illness / Injury | <input type="checkbox"/> Termination of Employment | <input type="checkbox"/> Inclement Weather |
| <input type="checkbox"/> Loss to home | <input type="checkbox"/> Abduction / Quarantine | <input type="checkbox"/> Felonious Assault |
| <input type="checkbox"/> Terrorist Incident | | |

Date & Time of Incident: Time

Person Affected : (Tick one)

- Insured
 Family Member
 Travelling Companion

If not the insured, then please give the following details,

Name of Person: _____

Address of Correspondence: _____

City: _____ State: _____ Pin Code:

Relationship with Insured: _____

Details of the reason for trip Cancellation/Interruption (how, where and reasons for the same): _____

Details of expenses:

Sr. No.	Expense details	Amount

The above information given is just a brief summary of the incident. Please attach more sheet to give details, if necessary. Please attach Medical reports and doctors statement if trip is cancelled or interrupted due to medical reasons. If due to employment reason, then termination letter from the company shall be submitted. If due to other insured events, police report confirming the incident shall be submitted. In case the cancellation or interruption is owing to the sickness, injury or death of a traveling companion, the original tickets of the insured and the traveling companion indicating travel to the same destination for the same dates needs to be submitted. All the bills / receipts of reasonable additional expenses incurred and/or proof of cancellation charges levied by the carriers shall be submitted.

Trip Delay

Reason for trip delay (Tick one)

- Illness / Injury
 Termination of Employment
 Inclement Weather
 Loss to home
 Abduction / Quarantine
 Felonious Assault
 Terrorist Incident
 Delay by Carrier
 Loss of passport, travel documents or money

Date & Time of Incident: Time

Person Affected: (Tick one)

- Insured
 Family Member
 Travelling Companion

If not the insured, then please give the following details,

Name of Person: _____

Address of Correspondence: _____

City: _____ State: _____ Pin Code:

Relationship with Person: _____

Details of the reason for trip delay (how, where and reasons for the same): _____

Details of expenses:

Sr. No.	Expense details	Amount

The above information given is just a brief summary of the incident. Please attach more sheet to give details, if necessary. Please attach Medical reports and doctors' statement, or police report confirming the incident causing the trip delay. In case the delay is owing to the sickness, injury or death of a traveling companion, the original tickets of the insured and the traveling companion indicating travel to the same destination for the same dates needs to be submitted. Please also attach all the bills / receipts of reasonable additional expenses incurred.

Missed Connections

Name of Carrier: _____

Actual Date & Time of Arrival: Time

Scheduled Date & Time of Arrival: Time

Date & Time of Departure for Connecting Flight: Time

Reason for delay: _____

Details of expenses:

Sr. No.	Expense Details	Amount

The above information given is just a brief summary of the incident. Please attach more sheet to give details, if necessary. Please attach confirmation from the airline, clearly mentioning the scheduled arrival time and the actual arrival time. The reason for delay in the flight also needs to be mentioned. All the bills / receipts of reasonable additional expenses incurred shall be submitted to the Company.

Was the ailment / incident caused due to / aggravated due to a pre-existing condition? Please give details: _____

Date of onset of ailment:

Nature of treatment: : _____

Dates of hospitalisation: From To

Reason for medical evacuation (if applicable): : _____

Reason for not continuing studies abroad: : _____

Tuition fees paid in advance for the year: | _ | _ | _ | _ | _ |

Due to death of sponsor or immediate family member

Name of the sponsor / immediate family member: | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ |

Cause of accident causing the demise of the sponsor / reason for death of immediate family member: _____

Nature of accident causing the demise of the sponsor: _____

Place of accident of the sponsor: | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ |

Name, address and telephone number of hospital / clinic where treatment was given to the sponsor / the immediate family member:

Name of treating doctor: _____

Details of medical / surgical treatment: _____

Dates of medical / surgical treatment: From To

Reason for not continuing studies abroad: _____

Tuition fees paid in advance for the year: | _ | _ | _ | _ | _ |

Please attach medical reports, statements from the treating doctor and death certificate as proof of the above. Medical statements from relations or spouse will not be accepted. Please also attach the receipts of the university fees paid. Please attach more sheets to give details, if necessary.

I/We hereby agree, affirm and declare that:

a. The statements/information given/stated by me/us in this claim form are true, correct and complete.

b. The details of all persons having an interest in the property in respect of which the claim is being made are provided as per the proposal form or by way of an endorsement in the policy. Furthermore, save and except as provided or disclosed in this claim form, no claim made hereunder (or the same/similar claim) has been made or lodged with any other insurance company.

c. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.

d. If I/we have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I/We shall not be entitled to all/any rights to recover thereunder in respect of any or all claims, past, present or future.

e. The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information and documents in respect of the claim.

Place:

Date: _____ Signature of the claimant

*Please read the policy wordings for detailed requirements of documents ICICI Lombard General Insurance Company Ltd. Insurance is the subject matter of the solicitation MISC 29,30,50