

## OVERSEAS TRAVEL INSURANCE CLAIM FORM

- This form must be signed and dated in all applicable sections.
- 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
- Please answer all questions completely. In case of insufficient space, please attach an additional sheet.
- 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 General Insurance 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



### 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

Signature