Bajaj Allianz General Insurance Company Limited

Ground Floor, 32/2 Ashoka Plaza, Next to Weikfield Company, Nagar Road,
Pune - 411 014. Phone No. : +91 20 3030 5858, 1800 22 5858, 1800 102 5858

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.

Certificate / Policy No. : _____ Period From : _____ to : _____

Whether Claim was notified : Yes ☐ No ☐ If Yes, Reference No. _____

If No, give reasons : _____

DETAILS OF PATIENT / INSURED PERSON

Name of Insured : _____ Phone Nos. (In India) : _____

Date of Birth : _____ Gender : M /F _____ Abroad : _____

Name of Claimant : _____ Phone Nos. : _____

Date of Birth : _____ Gender : M / F _____

Current Residence Address (Abroad) : _____

Date of arrival in overseas country : _____

Email ID : _____

Permanent Address (INDIA) : _____

Date of Scheduled return to India : _____

Passport No. : _____

Date of Departure : _____ From : _____ To : _____

Date of Arrival : _____ From : _____ To : _____

Please indicate whether claim is in respect of : Trip Delay ☐ Trip Delay & Missed Connection ☐ Trip Cancellation ☐ Trip Curtailment ☐

Hijack Cover ☐ Emergency Cash Advance ☐ Personal Liability ☐ Bail Bond ☐ Tuition Fees ☐

* Please complete the Section relevant to your claim.

TRIP DELAY ☐ OR DELAY AND MISSED CONNECTION ☐

Name of Carrier : _____

Flight No. : _____ Date : ____ /____ /____ From : _____ To : _____

Scheduled time of Departure : _____ Actual time of Departure : _____ No. of Hours delayed : _____

Cause of Delay : _____

Whether relevant certificate provided by carrier : Yes ☐ No ☐

MISSED CONNECTION :

Scheduled Date & Time of Arrival : Date : _____ Time : _____

Actual Date and time of arrival : Date : _____ Time : _____

Date & time of Departure of Connection Flight : Date : _____ Time : _____

TRIP CANCELLATION ☐ / CURTAILMENT ☐

Date of Loss : _____

Reason for trip cancellation / interruption : Illness or injury ☐ Death ☐ Quarantine ☐ Hijack ☐

Person affected : Insured ☐ Spouse ☐ Child ☐ Travelling companion ☐

Name of affected person : _____

Address of affected person : _____

_____

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

_____

_____

_____

Details of Expenses :						
Sr. No.	Expense Details	Amount Contracted / Paid	Amount refunded	Net Loss	Payment receipts	Refund / No refund letter

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, Discharge card / death certificate if reason is medical. Airline authority letter if Hijack / Quarantine.

HIJACK COVER

Name of Carrier : _____

Port of Hijack : _____

Port of Release : _____

Dates and time of Hijack : From : _____ at _____ hr To _____ at _____ hr _____

Please attach police report confirming the incident. It should contain the Passport number of the insured and period of Hijack.

FINANCIAL EMERGENCY

Date of Loss : _____

Circumstances of Loss : _____

_____

Was the Police informed : _____ If yes, Case NO : _____ Police Station : _____

Amount of Assistance required : _____

Name of Relative from whom the assistance amount is to be collected : _____

Address of Relative : _____

_____

Contact Number : _____

HOME BURGLARY INSURANCE

Address of property where loss was sustained : _____

_____

City : _____ State : _____ Pin Code : _____

Date of Loss : _____

Contents of Home : Loss : Damage : Both :

_____

Detailed Circumstances of the loss : _____

_____

Occupants of the property at the time of loss / By whom was the loss discovered ?

Have the authorities been informed of the Burglary ? If yes, By whom ? _____ at _____

If no, The reasons for not reporting : _____

Sr. No.	Details	Loss/Damage	Estimated Cost of loss

Details of any other insurance to cover for the Property : _____

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 police, invoices of owned articles (if required by company).

PERSONAL LIABILITY

Name of the Aggrieved Third Party : _____

Date of Loss : _____

Circumstances of Loss : _____

_____

_____

_____

Was the Police informed : _____ If yes, Case NO : _____ Police Station : _____

Legal Case No : _____ Legal Jurisdiction city : _____

BAIL BOND INSURANCE

Date of Loss : _____

Name and contact Details of Detaining Authority : _____

_____

_____

Details of offence for which the insured is in custody and circumstances leading to the offence : _____

_____

_____

Legal Case No : _____ Legal Jurisdiction city : _____

Is this offence bailable as per the laws of the country : Yes ☐ No ☐

TUITION FEES

Due to : Hospitalization of insured ☐ Death of Parent ☐ Serious injury of parent ☐

Name of affected person : _____

Address of affected person : _____

_____

Date of Hospitalization : From : _____ To : _____

Circumstances leading to the loss : (Ailment nature, treatment / cause of death / circumstances of accident)

_____

_____

Name address and telephone number of hospitals / clinic where treatment was given :

_____

_____

Reason for not continuing studies abroad _____

_____

_____

Details of Tuition fees :

Sr. No.	Expense Details	Amount Contracted / Paid	Amount refunded	Net Loss	Payment receipts	Refund / No refund letter

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, Discharge card / death certificate if reason is medical. Airline authority letter if Hijack / Quarantine.

PERSONAL ACCIDENT / ACCIDENT TO SPONSOR

Please indicate whether claim is in respect of : Personal Accident ☐ Accident to Sponsor ☐

If accident, details of accident i.e. how, when, where it took place : _____

_____

_____

Date : _____ Place : _____

Has the accident been reported to the Police ?_____ If yes, Case No : _____ Police Station : _____

Name & Address of consulting physician : _____

_____

_____

Provide name & address of your Regular physician in India : _____

_____

_____

Provide name of any prescription medicine you are presently taking : _____

Indicate other health insurance coverages, including name, address, policy number & certificate number of insurer :

_____

_____

PERSONAL ACCIDENT :

Loss Incurred : Death : ☐ Loss of Two Limbs : ☐

Loss of Two Eye : ☐ Loss of two limbs and one Eye : ☐

ACCIDENT TO SPONSOR :

Loss Incurred : Death : ☐ Loss of Two Limbs : ☐

Loss of Two Eye : ☐ Loss of two limbs and one Eye : ☐

Total Tuition fees : _____

Tuition fees already paid : _____

Balance tuition fees to be paid : _____

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agent group policy holder, insurance company, association, employer or benefit plan administrator to furnish to the insurance company named above or its representative, any and all information with respect to any injury or sickness suffered by, the medical history of, or consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payment under the Policy Number identified above. I authorize the group policy holder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment - related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I understand that I or my authorized representative may request a copy of this authorization

_____

Date : _____ Place : _____

Signature of Claimant or Parent, If claimant is a minor : _____

I hereby certify that the above information is true and correct to the best of my knowledge and belief.

Signature : _____ Date : _____