

Overseas Travel Insurance Claim Form

Guidelines for completion of the Claims form

- 1. Claims Form consists of two parts Information Sheet and Coverage
- 2. Please fill the Information Sheet along with the relevant annexure as per the desired coverage.
- 3. Please take the print out of only the relevant annexure.

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In the event of a	claim, contact our below 24 -hour helpline numbers
In USA	+18773527706 (Toll Free)
In Canada	+18773527706 (Toll Free)
In India	1800 2666 (Toll Free & Accessible in India only)
	+91 92236 22666 (Chargeable)
From the rest of the world	+91 22 6787 2010 (Call Back Facility)
Fax	+91 22 6734 7888
E-mail	icicilombard@europ-assistance.in
Claim Processing Department Address	ICICI Lombard General Insurance Company Limited, C/O Europ Assistance India Pvt Ltd. 301, C Wing, Business Squaree, Andheri Kurla Road, Chakala, Andheri (E), Mumbai - 400 093, India

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INFORMATION SHEET

Terms and conditions

- 1. The Insured shall ensure that the Insured has received, read and understood the terms and conditions as contained in Part II and III of the Policy. If the Insured has not received Part II and Part III of the Policy, please email at customersupport@icicilombard.com.
- 2. In the event of an Accident or sudden Illness or occurrence of any other contingency covered under the Policy, the Insured shall immediately contact the Help Line number and register his/her claim furnishing the necessary details.
- 3. Failure of immediate intimation to the helpline may result in the Insured's claim being prejudiced and in no case being admitted for more than 75% of the claim. No expenses however beyond a limit of US\$ 1000 shall be incurred by the Insured without prior approval from the Company.
- 4. This condition shall be applicable even in cases where the Insured would like to pursue his claim only on his return to his place of residence in spite of his meeting with the contingency covered herein whilst abroad.
- 5. Please note, Deductible amount as mentioned in Policy Schedule must be borne by you.
- 6. Issuance of the claims form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract.
- 7. No claim under Accident & Medical Section will be admitted without Doctor's Report as per format.
- 8. Please answer all questions completely. In case of insufficient space, please attach additional sheets.
- Please attach original of all bills, receipts, credit card slips pertaining to your claim. Every claim has to be accompanied with original ticket/ boarding pass or copy of passport indicating the travel dates.

DECLARATION

I/We hereby agree, affirm and declare that:

- 1. The statements/information given/ stated by me/ us in this claim form are true, correct and complete.
- 2. 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.
- 3. 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.
- 4. 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.
- 5. 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.
- 6. I do hereby authorize International Subrogation Management (ISM) to inquire and obtain any information regarding my accident. Further, ICICI Lombard is hereby authorized to release any and all information, including copies of pertinent documents, which ISM may deem necessary in order to satisfy their inquiry, If during the investigation, ISM has identified a potential recovery source, allowing the Plan Participant's employer to recover paid benefits, ISM is authorized to release any all records they deem necessary in order to pursue the recovery.
- 7. The company can, while assessing the claim, call for the additional documents which the Company deems fit for assessment of the claim.

	Claimant's/ Insured's Signature

AUTHORIZATION BY INSURED/ ON BEHALF OF THE INSURED

- 1. I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the Insured to release any information requested regarding this claim and the loss reported.
- 2. I understand ICICI Lombard General Insurance Company Ltd, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim, will use this information.
- 3. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original.
- 4. I agree that this authorization shall be valid for the duration of this claim. I also authorize Assistance Service Provider, on behalf of ICICI Lombard General Insurance Company Limited, to obtain any medical records or information to process this claim.
- 5. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Claimant or authorized person)	Relationship with the Insured
Dated: DD/MM/YYYY Place:	Insured's Signature

Annexure 1: MEDICAL COVER & DENTAL TREATMENT

OUT PATIENT T	REATMENT		
Nature of Ailment	t:		
State Diagnosis ar	nd nature of treatment taken:		
Dates of treatmen	t: From DD/MM/YYYY To: DD/MM		late of onset of symptoms: DD/MM/YYYY
Name, address &	telephone number of consulting physician/ dentist/ hospital	where treatment was	taken:
Have you ever bee	en treated for this illness before: Yes No If yes, pro	vide name, address &	telephone number of consulted physician:
Provide name, add	dress & telephone number of your family/ regular doctor in Inc	dia:	
Provide name of a	ny prescription medicine you are presently taking:		
Hospitalisation	(First)	(Middle)	(Last)
Full Name:			
	Hospital/Clinic:	ting Doctor's Name &	Qualifications:
		(M)	
•	nt: From: DD/MM/YYYY To: DD/MM	— — — —	rate of onset of Symptoms: D D J/ M J M J/ Y J Y J Y J Y J
Attending Doctor			
_	acted: DD/MM/YYYY Time: HH:M	Nature of Ailmo	ent:
	nd nature of treatment provided:		
•	's symptoms first appear?		
	er disease or infirmity affecting present condition:		
	due to Pregnancy: Yes No		
Was the ailment a	aggravated due to any pre-existing condition? Yes No	If yes, please g	ive details:
Can the patient be	e evacuated back to the Republic of India? Yes No	J	
Is Medical Evacua	ation back to Republic of India needed? Please give detaile	d reasons of the ailm	nent and reason for transportation:
		MENT EXPENSES DE	
Sr. No.	Details of treatment/ expenses	Date	Expenses in Foreign Currency
Total:			
Claiming also for	daily allowance		
	submitted in support of the claim:		
	rts and discharge summary issued by the Hospital furnishing	the name of the Insur	red, period of treatment, details of treatment rendered.
•	s for: paid towards Hospital accommodation, nursing facilities and	dother medical servic	es rendered
	I to the Medical Practitioner, special nursing charges, etc.	ouror mourour corvic	5515/105/50
-	ncurred towards any and all test and/ or examinations rende	red in connection wit	h the treatment.
_			rescriptions of the Medical Practitioner attending on the Insured.
	aims payable hereunder, the Company may effect settlemen ed, at its sole discretion. Cashless treatment facility cannot b		cashless treatment facility or by reimbursement of the amount of
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Claimant's/Insured's Signature

Annexure 2: REPATRIATION OF REMAINS

Sr. No.	Details of expenses	Date	Expenses in Foreign Currency
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	
Total:			
ocuments to be sı	ıbmitted in support of the claim:		
. Photocopy of the	, ,	e place, date and time, and the circumstance vider), issued by the appropriate authority wh	s and cause of the death (photocopy of the postmorte
certificate wher	ever required by the Assistance Service Prov	riuei į, issueu by tile appropriate autilority wi	iere trie contingency nas ansen.
	ever required by the Assistance Service Fro ees incurred towards disposal of the mortal re		ere the contingency has ansem.
. Proof for expens . In case of trans	es incurred towards disposal of the mortal reportation of the body of the deceased to the	emains. e Country of Residence of the Insured, the r	eceipt for expenses incurred towards preparation and leceased to the Country of Residence of the Insured.
. Proof for expens . In case of trans	es incurred towards disposal of the mortal reportation of the body of the deceased to the	emains. e Country of Residence of the Insured, the r	eceipt for expenses incurred towards preparation a

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Annexure 3: CHECKED-IN BAGGAGE LOSS/ DELAY			
Describe when & where the Loss/ Delay took place:			
State the extent of Delay/ Loss:			
Name the common carrier:			
Flight Details:			
1. Flight No.: From D	DJ/ MJ MJ/ YJ YJ YJ	Y To: DD/M	M/Y)Y)Y)
2. Flight No.: From		Y To: DD/M	M/Y/Y/Y
Port of Delay/Loss:			
Actual Date & Time of Arrival of flight at Port:	MM/YYYYY	<u>H]H]:M]M</u>	
Actual Date & Time when Bags were delivered: D/_	MM/YYYY	<u>H]H]:M]M</u>	
No. of Hours of bag delay: Had the co	ommon carrier been noti	fied at the time of loss	?? Yes No
Details of compensation received from carrier:			
Sr. No. Item Purchased/ Item	ıs Lost	Date of Purchase	Cost in Foreign Currency (In INR for loss claim)
Total:			
Compensation From Airlines:			
Net Amount:			
Documents to be submitted in support of the claim for	Checked-in Baggage I	.oss:	
		-In Baggage and the v	values thereof (excluding Valuables). Values of the items shal
represent their market value after allowing for age an	=		
2. Property irregularity report issued by the Common Ca		n./ahawt dalin.am.cafth.	o Charled In Baggaga
 Voucher of the Common Carrier for the compensation Copies of correspondence exchanged, if any, with the 	-		
			n Baggage, proof of ownership in the form of purchase bill (o
any other proof to the satisfaction of the Assistance S		Within the onecked-i	in baggage, proof of ownership in the form of parchase bill (o
		payment of the clair	m by the Company hereunder, the Insured shall repay to the
Company such amount in excess of his/ her loss after ta Carrier.	king into account the a	mount of claim receiv	ed from the Company and at that received from the Common
			ed for delivery to the Insured, the Insured shall take delivery o
			y of part of the Checked-In Baggage, the amount paid by the
Company attributable to such Checked-In Baggage shall be			
Documents to be submitted in support of the claim Cho		-	Charled In Paggaga isouad by the Common Comics
 Property irregularity report stating the scheduled time Voucher of the Common Carrier for the compensation 	•	· ·	
 voucher of the common carrier for the compensation Copies of correspondence exchanged, if any, with the 		*	
5. Copies of correspondence exchanged, if any, with the	5 COMMINUM CAMER III COI	mechon with the dela	y in uchvery of the Greckeu-III Dayyaye.

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Aillicx	ure 4: PASSP	OHI LUSS					
Please p	provide details	of the incident leading	g to loss of passport				
Date of I	oss of Passpor	t: <u>DD/M</u> M/_Y	JYJY Place of	loss of Passport	·		
Expense	es incurred in o	btaining new passpo	rt:				
Sr.	. No.	Deta	ils of Expenses		Date		Expenses in Foreign Currency
Total:	1						
Docum	ents to be sub	mitted in support of	the claim:				
1. Poli	ce Report in ori	iginal.					
2. Det	ails of the atter	npts made to trace th	e passport.				
3. Sta	tement of clain	n for the expenses inc	urred.				
		•	ining an emergency ce			passport.	
	-		ate passport at the Cou	-			
passpor and app	t or the duplica ly for the refun	ate passport at the Co d of the money paid v	untry of Residence of	the Insured is is emergency cer	sued to the Insure	d, the Insured sh	mergency certificate at the place of loss of the all intimate the concerned authorities forthwith e case may be. The Insured shall then refund to
Dated: _	D]D]/M]M	/ <u></u>	ace:				Claimant's/Insured's Signature

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Annexure 5: PERSONAL LIABILITY	
Date of Loss: DD/MM/YYYYY	
Place of Loss:	
Name of aggrieved Third Party:	
Amount of Liability:	
 Documents to be submitted in support of the claim Statement of claim furnishing particulars of the event leading t the liability/ details of injury/ property damaged. Photocopy of the police report wherever reported. 	
Dated: DD/MM/YYYY Place: Claimant's/Insured's Signature	

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Please state circumstances of accident i.e. how, when, where it took place: Nature of Injury: State diagnosis and nature of treatment/ surgery under taken: _ Provide name, address & telephone number of Hospital/Clinic: Treating Doctor's Name & Qualifications: Treating Doctor's Telephone Number: (0) Dates of treatment: From DD/MM/YYYY To: DD/MM/YYYYY Attending Doctor's Report Date doctor contacted: DD/MM/YYYY Time: HH: MM Nature of Ailment: State diagnosis and nature of treatment provided: Describe any other disease or infirmity affecting present condition: Was the accident due to Pregnancy: Yes ____ No ___ Was the accident due to any pre-existing condition: Yes ____ No ___ If yes, please give details: Can the patient be evacuated back to the Republic of India? Yes — No — Loss Incurred (Please tick): Death Permanent Total Disability: ____ (Details)_____ Permanent Partial Disability: (Details) Documents to be submitted in support of the claim: 1. Medical reports giving the details of the Accident, nature of Injury and the extent of disability. 2. In case of death of the Insured, death certificate issued by the Medical Practitioner who attended on the Insured. Postmortem certificate to be produced if required by the Assistance Service Provider. Police report in original in case the Accident shall have taken place in a public place or premises. Dated: DD/MM/YYYY Place: Claimant's/Insured's Signature

Annexure 6: PERSONAL ACCIDENT & ACCIDENTAL DEATH (COMMON CARRIER)

Broker: Loyal Insurance Brokers Ltd.
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the aircraft/ oc	cean going	vessels fu	ırnishing (details of tr	avel by th	e Insure	d, the	fact o	f his/ h	er bein	g held	captiv	e and c	onfirn	nation	of death
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Date of Loss: Doly Moly Y Y Y Y Reason and circumstances of Loss: Items lost: Value of the Items lost: Under of the Items lost: Value of the Items lost: I hereby declare that the above reason was the sole reason for the of my loss of travel funds. I also declare that there are no other sources of funds available to me and the financial assistance required by me are needed on an urgent basis to prosecute the remainder of my trip. I have made all efforts to recover my money unsuccessfully, and if I do secure my money at a future date, I shall repay to the Company the total claim amount given to me. SIGNED (Claimant or authorized person) Relationship with the Insured: Documents to be submitted in support of the claim: Police report in original filed within 24 hrs of becoming aware of loss Claimant's/Insured's Signature

Annexure 8: EMERGENCY CASH ADVANCE ASSISTANCE

: Loyal Insurance Brokers Ltd.
Broker
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www.insureatclick.com

ddress of property where loss was sustained: ate of Loss: DD/MM/YYYYY ause of Loss: cact description of nature of loss and it causes (in case of burglary, how was forceful entry gained into the premises and who is suspe	ected of the same):
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cact description of nature of loss and it causes (in case of burglary, how was forceful entry gained into the premises and who is suspe	ected of the same):
ccupants of the premises at the time of loss/ by whom it was discovered:	
as the loss been reported to the proper authorities? Yes No Please give details of where and to whom the loss has beer not time (If not reported, please give reasons for the same):	reported along with the date
etails of any other insurance cover for the property:	
etails of Loss Incurred:	
Sr. No. Items lost due to fire/ burglary	Amount
Total	
ocuments to be submitted in support of the claim	
First Information Report	
Panchnama	
Investigation Report by the Police	
Fire Brigade Report	
Estimate and final bills of repairers	
Invoices of owned articles, if required by the Company	
Legal opinion wherever required	
The statement of claim furnishing the details of items lost and the values thereof duly supported by purchase bills wherever purchase bills not being available, he/ she shall render such evidence as may be required by the surveyor for the latter to arrive at the surveyor for the surveyor for the latter to arrive at the surveyor for the survey or survey or surveyor for the survey or surveyor for the survey or surveyor for the survey or survey	
And any other document as may be appropriately applicable for the claims preferred under this section of the Policy.	
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An	nexure 10: T	RIP CANCELLATION & INTERRUPTION	
	Cancelled/		
	interrupted/		
Also	claiming for	rip Regained	
Rea	son for Trip Ca	ncellation/ Interruption:	
	se detail out t	ne above reason for trip cancellation/interruption (how, where, when and reason for the same):	
		Interruption date: DD/MM/YYYYY	
Orig	inal Travel Da	es:From: DD/MM/YYYY Time: HH:MM	
Pers	on Affected a	nd Relationship with the Insured: (If not the Insured, please also provide address and contact details)	
	ails of Losses	Expenses Incurred:	
	Sr. No.	Loss/ Expenses Details	Amount
		•	
То	tal:		
1.	solely result accompanied a. Confirma	tion of cancellation of the Trip from the Common Carrier detailing the circumstances of cancellation;	completed claims form to be
	cancellat	sed air ticket indicating the cost the ticket and receipt for the refund of the fare of the Common Carrier towards the c ion charges retained;	
	the amou	ill and a receipt/ letter obtained from the hotel and/ or guest house and/ or any other paid residential accommodation the paid for the accommodation, the refund given and the cancellation charges retained, wherever such accommodate ancellation of the Trip;	- ·
		icket in original for return journey from the place of cancellation to the Country of Residence of the Insured which with the receipts for the refunds obtained towards the unfulfilled portion of the Trip.	indicate the cost of the tickets
2.		ncellation of the Trip shall result because of personal contingencies covered hereunder or a decision taken at the ins encies namely Earthquake, Storm, Flood, inundation, cyclone, tempest & Terrorism, the duly completed claims form	_
		evidence as may be required by the Assistance Service Provider in case of the cancellation of the Trip arising out of rhis/her Immediate Family;	personal contingencies of the
	-	or the refund of the fare of the Common Carrier towards the cancelled portion of the Trip indicating the cancellation ch	-
		letter obtained from the for the hotel and/ or guest house and/ or any other residential accommodation (avaion charges retained, wherever such accommodation has be arranged at the place of cancellation of the Trip;	lable for a fee) indicating the
		ticket or boarding pass in original for return journey from the place of cancellation to the Country of Residence of or the refunds obtained towards the unfulfilled portion of the Trip.	the Insured together with the
3.		ncellation charges either for the Trip or part of it or in relation to the accommodation in a hotel/ guest house/ other	
		advantage of the Insured subsequent to any settlement of claim under this Benefit, the Insured shall forthwith return of such waiver.	n the sum paid by the Company

Dated: DD/MM/YYYY Place: _______

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Alliloxulo II.	WISSED (I FIGHT) GOINGEOTION	
Original Travel S	chedule: (Please give date and time of all flights, mentioning the original and actual arrival and departure times. Plea	ase also mention the name
of carriers and fl	ight numbers)	
Which flight was	delayed causing a missed connection?	
Reason for delay	of the flight:	
Details of expens	ses due to Missed Connection:	
Sr. No.	Expenses	Amount
Total		
Documents to b	e submitted in support of the claim:	
1. The confirmathe reasons	ation from the Common Carrier of the delayed flight as to the expected time of arrival and the actual time of arrival at the for delay.	e port of delay together with
2. Unused tick	et for the ongoing flight (Missed Flight) with an endorsement of the Common Carrier of cancellation of the same.	
3. Certificate fr	om the Common Carrier of the Missed Flight that the fare for the part of the Trip covered by the Missed Flight is forfeited of forfeiture.	in full or in part together with
4. Original used	I ticket obtained afresh towards the alternative flight for the part of the Trip covered by the Missed Flight indicating the a	mount paid as fare.
	ne forfeited amount by the Common Carrier for the Missed Flight being refunded / returned to the Insured, subsequent ared shall return the amount so refunded in full.	t to any payment under this

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Re	nnexure 12: T ason for Trip De	ay:	
0ri	ginal Travel Dat	ne reason for trip delay (how, where, when, what was lost and reason for the same): es: From: DD/MM/YYYYY To: DD/MM/YYYYYY	
Pei	rson Affected a	nd Relationship with the Insured: (If not the Insured, please also provide address and contact details)	
	tails of Expense	s Incurred:	
	Sr. No.	Loss/ Expenses Details	Amount
T	otal		
Do	cuments to be	submitted in support of the claim:	
		the Trip either at the Country of Residence of the Insured or any other intermediate place forming part of the Trip by tingencies namely Earthquake, Storm, Flood, inundation, cyclone, tempest & Terrorism, duly completed claims form to	-
a.	Confirmation	of cancellation of the Trip from the Common Carrier detailing the circumstances of cancellation	
b.	Receipt for the	refund of the fare of the Common Carrier towards the cancelled portion of the Trip indicating the cancellation charges	retained
C.		r obtained from the hotel and / or guest house and / or any other residential accommodation for a fee indicating the ca , wherever such accommodation has be arranged at the place of cancellation of the Trip	ancellation charges retained
d.	for the refund charges incu	t or boarding pass in original for return journey from the place of cancellation to the Country of Residence of the Insures obtained towards the unfulfilled portion of the Trip (As any payment under this head shall be only in respect of the direct for the return journey from the place of cancellation to the country of residence and the amounts obtained to the Trip. These documents shall be submitted only in case there shall be an additional expenditure incurred by the	fference between the actua owards refund towards the
		of the Trip shall result because of personal contingencies covered hereunder or a decision taken at the instance of t nely Earthquake, Storm, Flood, inundation, cyclone, tempest & Terrorism, the duly completed claims form to be accom	•
a.	A declaration	from the Insured furnishing the circumstances that compelled him/her to cancel the Trip	
b.	Medical evide Insured or his	ence as may be required by the Assistance Service Provider in case of the cancellation of the Trip arising out of pe / her Family	ersonal contingencies of the
c.	Receipt for the	refund of the fare of the Common Carrier towards the cancelled portion of the Trip indicating the cancellation charges	retained
d.		r obtained from the for the hotel and / or guest house and / or any other residential accommodation for a fee indicati	ng the cancellation charges
•		e agency, wherever such accommodation has be arranged at the place of cancellation of the Trip ith the Police having jurisdiction over the place of loss reporting the loss of the passport or travel documents and the	application made for a fresh
е.	•	infinite rollice having jurisdiction over the place of loss reporting the loss of the passport of travel documents and the rel documents.	application made for a fresi
f.	-	om the Insured that the passport / travel documents has been recovered / returned to him / her with the date of such	recovery / return or has no
		d/returned or that alternative passport has not been obtained within the period for which the indemnity shall be availa	
g.	for the refund charges incur	t or boarding pass in original for return journey from the place of cancellation to the Country of Residence of the Insures obtained towards the unfulfilled portion of the Trip (As any payment under this head shall be only in respect of the direct for the return journey from the place cancellation to the country of residence and the amounts obtained towards re	fference between the actua
	portion of the	Trip. These documents shall be submitted only in case there shall be an additional expenditure incurred by the Insured)	

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Α	nnexure 13: l	BOUNCED BOOKINGS- AIRLINES/ HOTELS	
Re	ason for Boun	ced Booking:	
Ple	ease detail out	the reason for the Bounced Booking (how, where, when, and reason for the same):	
_			
0r	iginal Travel/ A	accommodation Dates: From: DD/MM/YYYYY To: DD/MM/YYYYY	
	•	ne booking was bounced: DD/MM/YYYYY ses Incurred: DD/MM/YYYYY Ses Incurred:	
	Sr. No.	Loss/ Expenses Details	Amount
	Total		
Do	ocuments to b	e submitted in support of the claim:	
1.		n from the Insured that he/ she has strictly complied with the rules laid down by the Common Carrier or accommodation be reconfirmation of the booking prior to the date of departure of the flight or occupation of the accommodation.	n provider as the case may be
2.	•	on from the Common Carrier of the bounced booking solely at their instance and responsibility.	
3.	A confirmati	on from the accommodation provider of the bounced booking solely at their instance and responsibility.	
4.	have incurre	I lodge his/ her claim on the Common Carrier and/ or the accommodation provider as the case may be for the additional description of the forwhich he/ she has lodged a claim on this Company and in case of any recovery from the concerned agencies, shat extent of amount paid hereunder.	•
Da	ated: _D _D / _I	M] M] / Y Y Y Y Place: Claimant's/Ins	sured's Signature

	would continue to be in the hospital? Expenses Details		
Sr. No.	Loss/ Expenses Details	Date	Amount
Total			
relative during the enti 2. Discharge summary o days of Hospitalization	ted in support of the claim: Medical Practitioner recommending the presence in the form of special assistance to be the period of Hospitalization. Certificate to also specify the minimum period of Hospitalization of the Hospitalization of Hospitalization of Hospitalization of the Hospital furnishing details - date of admission, date of discharge, and the presence of the travel to and fro by the member of the Family or near relative.	on.	
relative during the enti 2. Discharge summary o days of Hospitalization	Medical Practitioner recommending the presence in the form of special assistance to be the period of Hospitalization. Certificate to also specify the minimum period of Hospitalization of the Hospital furnishing details - date of admission, date of discharge, and the presence of the travel to and fro by the member of the Family or near relative.	on. f the member of the	

Annexure 14: COMPASSIONATE VISIT

Treating Doctor's Name & Qualifications: Treating Doctor's Telephone Number: (0)

State diagnosis and nature of treatment provided:_

Relationship with the Insured: _

Date of onset of symptoms: **Attending Doctor's Report**

Nature of Ailment:

Person Hospitalised: Insured ____ Family Member ____ Name of the person hospitalized (if not the Insured):

Provide name, address & telephone number of Hospital/Clinic:

	1	otal												
	Do	cuments to be	submitted in suppor	t of the cl	aim:									
	1.	Receipt for the	e amount paid to the h	otel or gue	est house	or any oth	er accor	nmodatio	n provider	for a fee for th	ne charges	per day paid to	wards accommo	dation.
	2.	Evidence as n cyclone or Ter	nay be required by the rorism.	e Assista	nce Servic	ce Provide	er in cas	e the dela	y is cause	ed by Earthqua	ake, Flood	s resulting fron	n unseasonal rair	ns, storm or
	3.	obtained from	icate furnishing detain the Medical Practit sulting from any Injur	ioner in c	ase of de	lay being	caused	d because	of Hospit	talization of tl	he Insure	d or Insured's I	amily member o	
	4.		of passport, a copy o plication lodged with						omplaint lo	odged with the	e police ha	ving jurisdictio	n over the place o	of loss and a
s Ltd.	5.		of travel documents, ed could not undertake				with the	Common	Carrier for	the loss of th	e travel do	ocuments and a	confirmation fro	m the latter
ker		•	olely attributable to C								•		the said delay h	aving taken
Bro	pla	ce at their insta	nce together with a co	opy of the	claim mad	de on the	Commor	n Carrier fo	or expense	es incurred as	a result of	the delay.		
nce														
ura														
Broker: Loyal Insurance Brokers Ltd	Da	ted: <u>D</u> <u>D</u> / <u>M</u>		Place:		J					_	Claimant's/Ins	ured's Signature	
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Annexure 15: EMERGENCY HOTEL EXTENSION

Details of Losses/Expenses Incurred:

Please detail out the above reason for Delay (how, where, when and reason for the same):

Person Affected and Relationship with the Insured: (If not the Insured, please also provide address and contact details)

Loss/ Expenses Details

Date

Amount

Delay date: $\begin{picture}(10,10) \put(0,10){\line(1,0){10}} \put(0,10){$

Reason for Delay:

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Annexure 10	SE LUSS OF BAGGAGE & PERSONAL EFFECTS		
Date of Loss:	DD/MM/YYYY		
Reason and ci	rcumstances of Loss:		
	re that the above reason was the sole reason for the Loss of my baggage & cessfully, and if I do secure my baggage & personal effects at a future date, I	·	
SIGNED (Claim	nant or authorized person) Relationship with the Insured		
		 Relationship with the	o Inquired
Netails of Loss	es/Expenses Incurred:	neiauoristiip witii tiik	emsureu
Sr. No.	Loss/ Expenses Details		Amount
01101	2007, 21, 40000 20000		7 in our
Total:			
Details of com	npensation received:		
Doguments to	be submitted in support of the claim:		
 Copies of the Copy of the Reply if an 	the letter addressed to the Common Carrier, police authorities and hotel/gue first information report lodged with the police in relation to the complaint. By in original received from the above referred authorities. By as may be required by the Assistance Service Provider for certification of the		
Dated: DD	/_M_M/_Y_Y_Y_Place:	Claimant's/ Ins	sured's Signature

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Name of the person hospitalized (if not the Insured :		ospitalisation ed: Insured Family Member					
Relationship with the Insured:			1 1 1 1 1	1 1 1 1 1	1 1 1 1 1		1 1
Treating Doctor's Name & Qualifications:	•						//_
Treating Doctor's Name & Qualifications: Traiting Doctor's Telephone Number(I) Dates of hospitalisation. From							
Treating Doctor's Telephone Number: (I)	Provide name, ad	aress a telephone number of Hospital/ Clinic:					
Date of nospitalisation: From	•						
Total: Date of the submitted in support of the claim: 1. A certificate from the Medical Practitione recommending the presence in the form of special assistance to be rendered by a member of the Family or ne relative during the entire period of Hospitalization. 2. Discharge summary of the Hospitalization. 2. Discharge summary of the Hospitalization. 2. Discharge summary of the Hospitalization. 2. Original ticket(s) used for the travel by the Minor Child(ren) back to the Country of Residence, if the ticket(s) are bought on behalf of the Insured without an interference of the Company 4. Photocopy of the death certificate (wherever applicable) providing the details of the place, date and time, and the circumstances and cause of the dear (photocopy of the postmortem is conducted,), issued by it appropriate authority where the contingency has arisen.	Treating Doctor's	Telephone Number:(0)	(M)				
In Case of Death of the Insured Cause (Circumstances of death:) Catter of Allment Cause (Circumstances of death:) Catter death of the Cause of the Cause Can the patient of the Cause of Infirmity effecting present condition: Can the patient due to Pregnancy. Yes No No If yes, please give details: Can the patient due to Pregnancy. Yes No No Sas the ailment due to Pregnancy. Yes No No Sas the ailment due to Pregnancy. Yes No No Sas the ailment due to Pregnancy. Yes No No Sas the ailment due to Pregnancy. Yes No No Sas the ailment due to Pregnancy. Yes No No Sas the ailment due to Pregnancy. Yes No No Sas the ailment the patient would continue to be in the hospital? Yes No Sas Medical Evacuation back to Republic of India needed? Yes No Please give detailed reasons of the ailment and reason for transportation: Expenses Details			<u>J_M</u> J				
Cause/ Circumstances of death: Date of death of Insured: Attending Doctor's Report Date doctor contacted: Date of death of Insured: Date doctor contacted: Date of death of Insured: Date doctor contacted: Date of Aliment: State diagnosis and nature of treatment provided: When did patient's symptoms first appear? Describe any other disease or infirmity effecting present condition: Was the ailment due to Pregnancy, Yes No Describe any other disease or infirmity effecting present condition: Was the ailment agraywated due to any pre-existing condition? Yes No State insurant agraywated due to any pre-existing condition? Yes No Stemated time the patient would continue to be in the hospital? Yes No s Medical Evacuation back to Republic of India needed? Yes No Please give detailed reasons of the ailment and reason for transportation: Expenses Details Sr. No. Details of Expenses Date Expenses in Foreign Currency/ INR Total: Documents to be submitted in support of the claim: 1. A certificate from the Medical Practitioner recommending the presence in the form of special assistance to be rendered by a member of the Family or ne relative during the entire period of Hospitalization. Discharge summary of the Hospital furnishing details – date of admission, date of discharge, and the presence of the member of the Family or near relative on: days of Hospitalization. Original ticket(s) used for the travel by the Minor Child(ren) back to the Country of Residence, if the ticket(s) are bought on behalf of the Insured without ar interference of the Company 4. Photocopy of the postmortem certificate wherever required by the Assistance Service Provider, for cases where postmortem is conducted,), issued by the appropriate authority where the contingency has arisen.	Date of onset of s	/mptoms: DD/MM/YYYY					
Date of death of Insured: Attending Doctor's Report Nature of Adiment: State diagnosis and nature of treatment provided: When did patient's symptoms first appear? Describe any other disease or infirmity affecting present condition: Was the ailment due to Pregnancy: Yes No Was the ailment aggravated due to any pre-existing condition? Yes No If yes, please give details: Zant the patient be evacuated back to the Republic of India? Yes No Stimated time the patient would continue to be in the hospital? Yes No Stepenses Details Sr. No. Details of Expenses Date Expenses in Foreign Currency/ INR Total: Documents to be submitted in support of the claim: 1. A certificate from the Medical Practitioner recommending the presence in the form of special assistance to be rendered by a member of the Family or ne relative during the entire period of Hospitalization. 2. Discharge summary of the Hospital furnishing details – date of admission, date of discharge, and the presence of the member of the Family or near relative on: days of Hospitalization. 3. Original tackel, I sued for the travel by the Minor Child(ren) back to the Country of Residence, if the ticket(s) are bought on behalf of the Insured without ar interference of the Company 4. Photocopy of the postmortem certificate wherever required by the Assistance Service Provider, for cases where postmortem is conducted,), issued by the appropriate authority where the contingency has arisen.	In Case of Death	of the Insured	1 1 1 1 1		1 1 1 1 1		1 1
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Date doctor contacted:	Date of death of Ir	sured:					
Nature of Ailment: State diagnosis and nature of treatment provided: When did patient's symptoms first appear? Describe any other disease or infirmity affecting present condition: Was the ailment due to Pregnancy. Yes No Was the ailment aggravated due to any pre-existing condition? Yes No If yes, please give details: Zan the patient be evacuated back to the Republic of India? Yes No Sat the patient be evacuated back to the Republic of India? Yes No Sate diagnosis and nature of the ailment and reason for transportation: Expenses Details Sr. No. Details of Expenses Date Expenses in Foreign Currency/ INR Total: Documents to be submitted in support of the claim: 1. A certificate from the Medical Practitioner recommending the presence in the form of special assistance to be rendered by a member of the Family or near relative during the entire period of Hospitalization. Certificate to also specify the minimum period of Hospitalization. 2. Discharge summary of the Hospital furnishing details – date of admission, date of discharge, and the presence of the member of the Family or near relative on days of Hospitalization. 3. Original ticket(s) used for the travel by the Minor Child(ren) back to the Country of Residence, if the ticket(s) are bought on behalf of the Insured without an interference of the Company 4. Photocopy of the death certificate (wherever applicable) providing the details of the place, date and time, and the circumstances and cause of the dea (photocopy of the postmortem certificate wherever required by the Assistance Service Provider, for cases where postmortem is conducted,), issued by the appropriate authority where the contingency has arisen.			1				
State diagnosis and nature of treatment provided: When did patient's symptoms first appear? Describe any other disease or infirmity affecting present condition: Was the ailment due to Pregnancy. Yes No If yes, please give details: Zan the patient be evacuated back to the Republic of India? Yes No Statisticated time the patient would continue to be in the hospital? Yes No Please give detailed reasons of the ailment and reason for transportation:	Date doctor conta	cted: DD/MM/YYYY Time: HH: MM	J				
When did patient's symptoms first appear? Describe any other disease or infirmity affecting present condition: Was the ailment due to Pregnancy: Yes	Nature of Ailment	:					
Describe any other disease or infirmitry affecting present condition: Was the ailment due to Pregnancy: Yes No Mas the ailment due to Pregnancy: Yes No If yes, please give details: Zan the patient be evacuated back to the Republic of India? Yes No Is Medical Evacuation back to Republic of India needed? Yes No Please give detailed reasons of the ailment and reason for transportation: Expenses Details	State diagnosis a	nd nature of treatment provided:	_ _ _	_ _ _ _ _			_ _ _
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Was the ailment aggravated due to any pre-existing condition? Yes No If yes, please give details: Can the patient be evacuated back to the Republic of India? Yes No Settimated time the patient would continue to be in the hospital? Yes No Please give detailed reasons of the ailment and reason for transportation: S Medical Evacuation back to Republic of India needed? Yes No Please give detailed reasons of the ailment and reason for transportation: Expenses Details	Describe any othe	er disease or infirmity affecting present condition:					_]_]_
Can the patient be evacuated back to the Republic of India? Yes No Statimated time the patient would continue to be in the hospital? Yes No Please give detailed reasons of the ailment and reason for transportation: Expenses Details	Was the ailment o	lue to Pregnancy: Yes No					
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Expenses Details Sr. No. Details of Expenses Date Expenses in Foreign Currency/ INR Total: Documents to be submitted in support of the claim: 1. A certificate from the Medical Practitioner recommending the presence in the form of special assistance to be rendered by a member of the Family or ner relative during the entire period of Hospitalization. Certificate to also specify the minimum period of Hospitalization. 2. Discharge summary of the Hospital furnishing details – date of admission, date of discharge, and the presence of the member of the Family or near relative on a days of Hospitalization. 3. Original ticket(s) used for the travel by the Minor Child(ren) back to the Country of Residence, if the ticket(s) are bought on behalf of the Insured without ar interference of the Company 4. Photocopy of the death certificate (wherever applicable) providing the details of the place, date and time, and the circumstances and cause of the dear (photocopy of the postmortem certificate wherever required by the Assistance Service Provider, for cases where postmortem is conducted,), issued by the appropriate authority where the contingency has arisen.	Can the patient be	evacuated back to the Republic of India? Yes No					
Expenses Details Sr. No. Details of Expenses Date Expenses in Foreign Currency/ INR Total: Documents to be submitted in support of the claim: 1. A certificate from the Medical Practitioner recommending the presence in the form of special assistance to be rendered by a member of the Family or ner relative during the entire period of Hospitalization. Certificate to also specify the minimum period of Hospitalization. 2. Discharge summary of the Hospital furnishing details – date of admission, date of discharge, and the presence of the member of the Family or near relative on a days of Hospitalization. 3. Original ticket(s) used for the travel by the Minor Child(ren) back to the Country of Residence, if the ticket(s) are bought on behalf of the Insured without ar interference of the Company 4. Photocopy of the death certificate (wherever applicable) providing the details of the place, date and time, and the circumstances and cause of the dear (photocopy of the postmortem certificate wherever required by the Assistance Service Provider, for cases where postmortem is conducted,), issued by the appropriate authority where the contingency has arisen.	Estimated time th	e patient would continue to be in the hospital? Yes No	J				
Expenses Details Sr. No. Details of Expenses Date Expenses in Foreign Currency/ INR Total: Documents to be submitted in support of the claim: 1. A certificate from the Medical Practitioner recommending the presence in the form of special assistance to be rendered by a member of the Family or nerelative during the entire period of Hospitalization. Certificate to also specify the minimum period of Hospitalization. 2. Discharge summary of the Hospital furnishing details – date of admission, date of discharge, and the presence of the member of the Family or near relative on a days of Hospitalization. 3. Original ticket(s) used for the travel by the Minor Child(ren) back to the Country of Residence, if the ticket(s) are bought on behalf of the Insured without are interference of the Company 4. Photocopy of the death certificate (wherever applicable) providing the details of the place, date and time, and the circumstances and cause of the dea (photocopy of the postmortem certificate wherever required by the Assistance Service Provider, for cases where postmortem is conducted,), issued by the appropriate authority where the contingency has arisen.			e give detailed reaso	ns of the ailment an	d reason for transp	ortation:	
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Reason for Evacuation:		
Please detail out the above	e reason for Evacuation (how, where, when and reason for the same):	
Evacuation date: DD/	MM/YYYY Original Travel Dates: From: DD/MM/YYYY Time: H	<u> H: M M</u>
Details of Losses/ Expense	es Incurred:	
Sr. No.	Loss/ Expenses Details	Amount
Total:		
Documents to be submit	ted in support of the claim:	
1. Official Declaration by	embassy of Country of Residence of the Insured.	
2. Original Invoice of Hot	el Accomodation during the period Insured is unable to return to the Country of Residence.	
3. Original ticket(s) used	for the travel back to the Country of Residence.	
Dated: D D M M M Y	Y Y Y Place:	laimant's/Insured's Signature

Annexure 18: POLITICAL RISK AND CATASTROPHE EVACUATION

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Annexure 19: BAIL BUND
Name and contact details of the detaining authority:
The offense for which the insured is in custody:
Is this offense bailable as per the laws of the country? Yes No
Please attach the court order stipulating the required amount as bail bond. Please attach more sheets to give details, if necessary.
Dated: DD/MM/YYYY Place: Claimant's/Insured's Signature

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Annexure 20: Sponsor Profection
Name of the sponsor:
Cause of accident causing the demise of the sponsor:
Nature of injury 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:
Name of treating doctor of the sponsor:
Details of medical/ surgical treatment given to sponsor:
Dates on which the sponsor was given medical/surgical treatment: From: DD/MM/YYYYY To: DD/MM/YYYYY
Please attach medical reports, doctor's statement giving the details of the sponsor and cause of death, and the death certificate of the sponsor. Medical statements from relations/ spouse will not be accepted. Please attach more sheets to give details, if necessary.
Tuition fees Claimed:
Dated: DD/MM/YYYY Place: Claimant's/Insured's Signature

Annexure 21: STUDY INTERRUPTION
Due to hospitalisation of the insured
Name, address and telephone number of hospital/clinic where treatment is being given:
Name of treating doctor:
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: DDMM/YYYY Nature of treatment:
Dates of hospitalisation: From: DD/MM/YYYY To: DD/MM/YYYY
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: DD/MM/YYYYY To: DD/MM/YYYYY
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.
be accepted. Flease also attach the receipts of the university fees paid. Flease attach more sheets to give details, if necessary.
Dated: DD/MM/YYYY Place: Claimant's/Insured's Signature

