TATA-AIG GENERAL INSURANCE COMPANY LIMITED

OVERSEAS TRAVEL INSURANCE CLAIM FORM

For Accident / Sickness Medical Expenses Reimbursement Only

IMPORTANT:

Please contact our 24-hour helpline (our Assistance Center) on

For the Americas Policies:+ +1-833-440-1575 (Toll free within US and Canada)
Email: tata.aig@europ-assistance.in (US and Canada)

For rest of the world policies excluding the Americas:Ph : +91 – 022 6822 7600 (ROW)
Email: EA.TATAclaims@europ-assistance.in

Failure to call our Assistance Company on 24-hour helpline, in respect of Medical Accident & Sickness Claims shall invalidate your claim, if any.

1. This is a One Call Claim Form, except for Accidental Death & Dismemberment (ADD). For ADD, we shall provide a separate Claim Form upon notification.
2. Issuance of the form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract.
3. No claim under Accident & Sickness Section will be admitted without Doctor's Report as per format (Attending Doctor's Report - Page 2)
4. Please answer all questions completely. In case of insufficient space, please attach an additional sheet.
5. Please attach all Original bills& receipts pertaining to your claim.

Insurance Card No. / Payana No. _____ **Period From** _____ **to:** _____

DETAILS OF PATIENT/ INSURED PERSON

Name of the Insured :-
Name of the Employee : _____ **Employee No.** _____
Name of the Claimant : _____ Phone Nos. _____
Permenant Address (INDIA): _____

Bank Account Name (in INDIA) : _____ Account NAME.: _____
Bank Account No.: _____ IFSC Code
Name of the Bank & Address : _____

Account NAME.: _____

Email Id : _____
Date of Birth: ___/___/___ Sex: M / F _____
Assistance Company Ref No.: _____ Passport No.: _____
Date of Departure: ___/___/___ Flight No. _____ From _____ to _____
Date of Arrival: ___/___/___ Flight No. _____ From _____ to _____

MEDICAL ACCIDENT & SICKNESS BENEFIT / ACCIDNETAL DEATH / DM / RMR/ SICKNESS DENTAL RELIEF / EMERGENCY MEDICAL EVACUTAION

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

Date: _____ Place: _____
If sickness, state nature and diagnosis, and advise when & where symptoms first occurred: _____

Date: _____ Place: _____
Name & Address of consulting physician: _____

Have you ever been treated for this illness before: ☐ Yes ☐ No
If yes, provide name & address of consulted physician: _____

Provide name & address of your family physician: _____

Provide name of any prescription medicine you are presently taking: _____
Indicate other health insurance coverages, including name, address, policy number & certificate number of insurer:

AUTHORIZATION

I hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish to the company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records, a photostat copy of this authorization shall be considered as effective and valid as the original.

Date: Place:

Signature of insured : _____

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	

Whether Assistance Co. was contacted: Yes No. If Yes, Reference No. _____

If No, give reasons: _____

Attending Doctor's Report

Patient's Name: _____ Age: _____ Sex: M / F

Address: _____

Date contacted: _____ Time: _____

Nature of Injury/ sickness : _____

Details of incidence

Diagnosis and Treatment Given: _____

When did patient's symptoms first appear: _____

Describe any other disease or infirmity affecting present condition: _____

Is condition due to Pregnancy: Yes ☐ No ☐ Is illness due to any pre-existing condition: Yes ☐ No ☐

Signature: _____

Attending Doctor's Signature

ACCIDENTAL DEATH & DISMEMBERMENT

Patient's Name: _____ Age: _____ Sex: M / F

Address: _____

Date / Place of Death :- Death Certificate No :-

FIR No : -

Details of Death :-

LOSS/DELAY OF CHECKED BAGGAGE

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

State the extent of Loss: _____

Name the common carrier: _____

1. Flight No._____From_____to _____
2. Flight No._____From_____to _____

Has the common carrier been notified at the time of loss? Yes☐ No ☐ Airline Reference No. _____
Details of compensation received from carrier: _____
Scheduled date/time of Arrival:__/__/__;__:__hrs. Actual date/time when bags delivered :__/__/__;__:__hrs
No. of Hours delayed :_____

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 incurred	Date	Place	Amount
		TOTAL	

TRAVEL DELAY/ FLIGHT DELAY

Flight No._____Date__/__/____From_____to_____
Scheduled time of Departure:_____Actual time of Departure:_____No. of Hours delayed:_____
Whether accomodation & boarding provided by carrier: Yes ☐No ☐

Details of Expense incurred	Date	Place	Amount
		TOTAL	

TRIP CANCELLATION / TRIP INTERRUPTION/ TRIP CURTAILMENT

Flight No._____Date__/__/____From_____to_____

Scheduled time of Departure:_____Cause for Cancellation / Interruption/ curtailment :_____

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

***Please note that this coverage applies if Trip is cancelled due to Illness, Injury or death to: You; Your Traveling Companion; Your Immediate Family**

PERSONAL LIABILITY

Please provide details of injury/ property damaged: _____

Have you received a legal notice, if Yes ,please furnish a copy (Yes/ No)

BOUNCED BOOKING OF HOTEL AND AIRLINES

Flight No._____Date__/__/____From_____to_____
Scheduled date of booking:_____Cause for bounced booking at hotel / airline :_____

Details of Expense incurred*	Date	Place	Amount
Amount refunded by the airline/ hotel			
		TOTAL	

MISSED DEPARTURE/ MISSED CONNECTION

Flight No._____ Date____/____/_____ From_____ to_____

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

Whether accommodation & boarding provided by carrier: Yes ☐ No ☐

Details of Expense incurred	Date	Place	Amount
		TOTAL	

HIJACKING

Flight Details: No._____ From_____ to_____

Scheduled Date & time of Departure:_____ Scheduled date & time of arrival:_____

Date and time of Hijack:_____ Date & time Returned: _____

Please provide details of incident: _____

FRADULANT CHARGES

Card NO:-	Date of Lost Card :-
Date & Time when the lost card inform to card issuer :-	
FIR Details :-	
Card Details :-	
Details of charges made on lost card	
Cash advances made on card if any	

HOME BURGLARY

Incident Details	FIR / Panchanama no :

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

Estimated Loss Details :-

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.

Registered Office to Submit the documents :- Peninsula Business Park, Tower A, 15th Floor, G.k. Marg, Off. Senapati Bapat Marg, Lower Parel, Mumbai - 400013.

Correspondence address to submit claim documents: A-501, 5th Floor, Building no 4, Infinity Park, Gen A.K. Vaidya Marg, Dindoshi, Malad (E) , Mumbai - 400097

Signature Date Place