CHECKLIST FOR TRAVEL CLAIM

- Claim Form (to be filled and signed by insured)
- Attending Physician Statement (to be filled and signed by overseas treating doctor)
- Release of Medical Information Form (ROMIF) AGA (to be filled and signed by insured) to obtain the medical records from facility
- Medical records/Consultation Papers/Investigation Reports
- Invoices / Bills against the medical expenses
- Original Paid receipts (hardcopy) in case of reimbursement claim.
- Kindly fill the NEFT section in claim form along with Cancelled cheque stating insured's / Claimant name and Indian Bank account details
- Visa copy with Entry Stamp Overseas and exit Stamp from India
- Any other documents if required will be notified to you by the claims department

Bajaj Allianz General Insurance Co. Ltd.

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Relationship Beyond Insurance

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.

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

Name of the Employee

Name of the Claimant

Phone Nos Overseas

Permanent Address

City State PIN

Phone (O) Phone (R) Mobile

Fax E-mail

Date of Birth D D M M Y Y Y Y Passport No.

Date of Departure D D M M Y Y Y Y Flight No. From To

Date of Arrival D D M M Y Y Y Y Flight No. From To

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 Allianz General Insurance Company Limited, to seek necessary medical information / documents from any hospital / Medical Practitioner who ha s 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: D D M M Y Y Y Y

Place: _____

Signature of the Insured

PLEASE COMPLETE THE SECTION RELEVANT TO YOUR CLAIM

☐ MEDICAL EXPENSES ☐ DENTAL TREATMENT ☐ MEDICAL EVACUATION ☐ HIV

☐ MATERNITY AND BABY COVER ☐ MENTAL ILLNESS AND ALCOHOL RELATED DISORDER ☐ CANCER SCREENING ☐ HOSPITALIZATION DAILY ALLOWANCE

☐ CANCER SCREENING AND MAMMOGRAPHY ☐ MEDICAL REPATRIATION ☐ PRE EXISTING ILLNESS ☐ 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

Diagnosis _____

if sickness-state nature of diagnosis and advise when and where symptoms first occurred _____

Kindly confirm nature of Injury: Self Inflicted Accident

Substance Abuse/Alcohol Consumption at the time of accident ☐ Yes ☐ No

If Accident kindly confirm how where and when it happened _____

Kindly confirm if accident reported to Police Station ☐ Yes ☐ No(If yes Kindly attached FIR copy)

Treatment Taken Outpatient_____ Inpatient _____

Treatment Type- Medical - ☐ Yes ☐ No or Surgical - ☐ Yes ☐ No

Kindly Provide name and address of diagnostic center in India where regular health checkup/investigations carried out _____

Provide name of medicine you were taking prior to departure from India: _____

Indicate other Travel/Health insurance coverage's, including name, address, policy number & certificate number of insurer: _____

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	

LOSS /DELAY OF CHECKED BAGGAGE

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

_____

State the extent of Loss: _____ Name the airline: _____

1. Flight No._____ From_____ to_____ 2. Flight No.._____ From_____ to_____

Has the airlines been notified at the time of loss? ☐ Yes ☐ No Airline Reference No._____

Details of compensation received from airline: _____

Scheduled date/time of Arrival: D D M M Y Y Y Y ☐☐ hrs.

Actual date/time when bags delivered D D M M Y Y Y Y ☐☐ hrs. No. of Hours delayed : ☐☐ hrs.

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: D D M M Y Y Y Y Place:_____

Details of Expense/Loss Incurred*	Date	Place	Amount
		TOTAL	

TRIP DELAY

Flight No._____ Date D D M M Y Y Y Y From_____ to_____

Scheduled date/time of Arrival: D D M M Y Y Y Y ☐☐ hrs.

Actual date D D M M Y Y Y Y ☐☐ hrs. No. of Hours delayed : ☐☐ hrs.

Reason for trip delay: _____

_____

Details of Expense Incurred	Date	Place	Amount
		TOTAL	

TRIP CANCELLATION/ /TRIP CURTAILMENT

Flight No._____Date D D M M Y Y Y Y From_____to_____

Scheduled time of Departure: ☐☐ hrs. Reason for Cancellation/ /Curtailment :_____

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 D D M M Y Y Y Y From_____to_____

Actual date/time of departure D D M M Y Y Y Y ☐☐ hrs. No. of Hours delayed : ☐☐ hrs. ☐ Yes ☐ No

HIJACK

Flight No._____Date D D M M Y Y Y Y From_____to_____

Scheduled date/time of Departure: D D M M Y Y Y Y ☐☐ hrs. Date & time of Hijack D D M M Y Y Y Y ☐☐ hrs.

Scheduled date/time of Arrival: D D M M Y Y Y Y ☐☐ hrs. Date & time of Returned D D M M Y Y Y Y ☐☐ 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: D D M M Y Y Y Y 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: D D M M Y Y Y Y

Place: _____

Signature

Bajaj Allianz General Insurance Company Limited
Ground Floor, 32/2 Ashoka Plaza, Next to Weikfield Company, Nagar Road,
Pune - 411014. Phone No. : +91 20 30305858, 18002 25858, 1800 102 5858

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ATTENDING PHYSICIANS STATEMENT

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

Address : _____

_____

_____

Date of first consultation : _____ Time : _____

For Accidental Injury

Nature of Injury : _____

_____

X-Ray Taken : Yes ☐ No ☐ Date taken : _____

Diagnosis and Treatment Given : _____

_____

_____

Are the injuries solely due to the accident or traceable to any previous injuries / disease _____

Please mention past history with duration of any diseases, accidents or hospitalizations with details : _____

_____

Was he under the influence of intoxicants / alcohol or drugs at the time of accident ? _____

For Sickness

Nature of Illness : _____

_____

_____

History of Presenting complaints : _____

_____

Diagnosis and Treatment Given : _____

_____

_____

_____

When did patient's symptoms first manifest : _____

Please mention past history with duration of any diseases, accidents or hospitalizations with details : _____

_____

_____

History of the following :-

Ailment	Yes / No, If yes Duration	Ailment	Yes / No, If yes Duration
Hypertension		Diabetes	
Cardiac ailments		Asthma	
Arthritis		Cancer	

Is this claimant Totally Disabled from each and every occupation ? _____

How long would the claimant be totally disabled ?

How long would the claimant be partially disabled ?

Prognosis of the ailment / injury : _____

_____

Signature : _____ Date : _____ Reg. No. : _____

Attending Doctor's Signature and Stamp

Doctor's Name : _____

Address & Phone No. : _____

_____

Allianz
Global Assistance

Authorization for medical records/patient information

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Patient Account #: _____

_____

Patient's Allianz Global Assistance case #: _____ DOS: _____

I hereby authorize the Medical Records Department staff at _____ (Facility/Physician name) to release information from my medical records to:

Allianz Global Assistance
PO Box 71987, Richmond, VA 23255 - 1987

Telephone: 519 741 0429 **Fax: 519 742 8720**
Email: MGCC-NA-CM@allianz-assistance.ca

For the purpose of: (Please check all that apply)

__ Continued Treatment __ Legal Review __ Insurance purpose
__ Personal review of information __ Other (Please specify) _____

I limit the information to be released to the following items: (Please check all that apply)

__ All Pertinent Records
__ Discharge Summary __ Consultation __ Diagnostic test (eg. Lab, x-ray, radiology)
__ Operative Report __ Emergency Dept Report __ History and Physical
__ Dental Report __ Other (Please Specify) _____

I understand that this authorization will allow Allianz Global Assistance to use the information obtained to investigate and adjudicate my claims. I am aware that refusal to release all or any of the information listed above could result in denial of my insurance claims.

I understand that medical records may be disclosed to certain third parties for insurance adjudication purposes and assistance services by Allianz Global Assistance.

I understand that I can revoke this authorization at any time by contacting Allianz Global Assistance in writing, except to the extent that action has already been taken on this authorization.

I understand that the information disclosed pursuant to this authorization may include psychiatric, drug or alcohol, or HIV information if that applies to me; my signature authorizes the release of any such information. ___ I **do not** consent to releasing information related to: __ HIV/AIDS __ Mental Health __ Drug and/or Alcohol Abuse

Unless I revoke this authorization earlier, **it will expire 1 year from the date signed** or as specified: _____

Signature of Patient/Legal Representative X _____ Date: _____

If other than patient, relationship to patient _____ Witness: _____

How can we help?

In Canada:
Allianz Global Assistance
P.O. Box 277
Waterloo, ON
N2J 4A4 Canada
Phone 519 741 0429
Fax 519 742 8720
Website www.allianz-assistance.ca

In the USA:
Allianz Global Assistance
P.O. Box 71987
Richmond, VA
23255-1987 USA

Legal Entities:
AZGA Service Canada Inc.
AZGA Insurance Agency Canada Ltd.

Mandate Form for Electronic Transfer of Claim Payments

To **Bajaj Allianz General Insurance Company Ltd**	**Office Code & Name :** **i-track Number :**

Partner ID *(To be filled by Office)*:

Full Name:

Shri / Smt / Kum / M/s _____
(As appears in your bank account)

Full Address: _____

_____ PIN Code: _____

Contact / Mobile No: _____ Email ID: _____

Bank Name:											
Branch Name & Address:											
Branch Tel No & Contact No:											
Branch IFSC Code for NEFT											
Branch MICR Code											
Name of the Account Holder : (As per Bank Account)											
Account Type		Savings			Current			Cash Credit			
Account No. (as appearing in the cheque book)											

I/we have read the declarations / conditions mentioned overleaf.

Place: _____ Date: _____ (Beneficiary's Signature) X _____

MANDATORY REQUIREMENT

PLEASE ATTACH HERE

Cancelled blank Cheque of your bank for ensuring accuracy of name of the bank, branch name, Account number and IFSC code. If NAME OR IFSC code of the payee is not printed on the cheque leaf, please attach copy of the first page of the bank passbook also.

I have verified the documents attached with the mandate and confirm that these documents correctly belong to the Partner ID & Partner Name mentioned in the mandate. (To be verified by superior)

Employee Code_____ Employee Name:_____ Designation_____

Place _____ Date_____ Signature _____