## 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



**Relationship Beyond Insurance** 

## OVERSEAS TRAVEL INSURANCE CLAIM FORM

- 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.

<ol> <li>Please attach all O</li> </ol>	riginal	&sillid	eceip	ts pe	rtain	iing	to yo																															
Insurance Cert. No./Card N	No																																					
Is the claim intimated Yes									If	No ki	ndly	conf	firm	reaso	n _																							
DETAILS OF PAT	TIENT/	INSU	RED F	PERS	-	rst car	Sales ne Y									(M)	ddle n	ame)											(Las	t nan	ne)							
Name of the Insured	П	П	П	T	T			T	T	T		T	T	T		Ì	T	T	T	T				T		T	П	T	П									
Name of the Employee	T	П	TT	T	T		T	Ť	Ť			T		T		T	T	T	T	T				T	T	T	T	T	T							П	T	
Name of the Claimant	T	TT	T	T			T	T	T	T		T	T	T			T	T	T	T			Ī	T	T		T	T	T								T	
Phone Nos Overseas			TT	t	T		T	T	T	T		T	T	T			T	T	T	T				T			T	T	T									
Permanent Address	T		Ħ		T		T	T	Ī	T		T	T	T		T	T	T	T	T				T		T												
City	T	II	T	T	T		T	T	T	T		Ť		State		T	T	T	T	T				I				T	T		P	IN						
Phone (O)	T		TT		T			T		Pho	ne (R	) [					T	T	T	I					N	Nob	ile											
Fax	П	T	П	T	T			T		E-I	mail													ð														
Date of Birth	D D	M h	Y	YY	У	]	Passp	ort	No.			I					-	I	I																			
Date of Departure	D D	IVI N	Y	YY	Y		Flig	ht N	0.				I				I			Froi	n_								To	o								
Date of Arrival	D D	MA	Y	Y Y	Y		Flig	ht N	0.			I	Ì	T			I	I		From	m								To	o								
DETAILS OF INSURED'S IN	DIAN B	ANK AG	COUN	II (Si	ubmi	issio	n of	Cano	elle	d Bla	ank (	Cheq	ue l	eaf w	ith I	Paye	e Na	me	Prin	ted	OR C	ору	oft	he F	irst	t pag	ge d	f th	e B	ank	Pas	sbo	ok	is M	and	lato	ry)	
Name of the Account Hold	der (As p	oer Bar	k Acco	ount)				T	T			T	T							T				T														
Account No (As appearing	in the o	heque	book)					Ť	T	T			T	T			I	T	I	I				I														
Bank Name											1																											
Branch Name & Address														de la															_		_			_				
	Saving		] Cu	rrent	_		Ca	sh C	redi	t		_	_	_	1 .		- 1		_	_				_	_		_	_	_									
MICR No.				+	+		_	+	+	_					1		Code		L						_			$\perp$					Ш		$\Box$	Ш	_	
PAN								- 1					T																									
DECLARATION  I hereby declare that the	inform	ation f	urnish	ed in	this	clai	m fo	mi	tru	- 8. i	COLLE	ect to	o the	hest		heq ny ki							have	ma	ade	any	/fal-	seo	rur	ntri	ie st	ate	mei	nt. s	upr	ores	sior	10
I hereby declare that the concealment of any mat General Insurance Completing is made. I hereby d Date:	terial fac bany Lin	ct with nited, 1	respe o seek	ct to	que: essai	stior ry m	ns asl edica	ked i	in re form	latio	n to	this locu	clai mer	m, m	of n y rig	ny ki ht to ny h	nowl o cla ospi	edg im re	e ar eim Me	nd be	elief. eme	If I ent	shal one	l be rwh	for no h pler	feite na s mer	ed. atte	als nde y cla	o co ed o aim	ons on th	ent he p	& a	uth	oriz	e Ba	ajaj /	Allia	an
I hereby declare that the concealment of any mat General Insurance Comp claim is made. I hereby d	terial fac pany Lin eclare t	ct with nited, 1	respe o seek	ct to	que: essai	stior ry m	ns asl edica	ked i	in re form	latio	n to	this locu	clai mer	m, m	of n y rig	ny ki ht to ny h	nowl o cla ospi	edg im re	e ar eim Me	nd be	elief. eme	If I ent	shal one	l be rwh	for no h pler	feite na s	ed. atte	als nde y cla	o co ed o aim	ons on th	ent he p	& a	uth	oriz	e Ba	ajaj /	Allia	an
I hereby declare that the concealment of any mat General Insurance Completing is made. I hereby d Date:	terial fac pany Lin eclare ti	et with nited, I nat I ha	respe o seek ve inc	ct to nece lude	que: essar d all t	stior ry m the b	ns asl edica pills /	rece	in re form eipts	latio natio	n to n / d he p	this locul urpo	clai mer	m, m	of n y rig	ny ki ht to ny h	nowl o cla ospi	edg im re	e ar eim Me	nd be	elief. eme	If I ent	shal one	l be rwh	for no h pler	feite na s mer	ed. atte	als nde y cla	o co ed o aim	ons on th	ent he p	& a	uth	oriz	e Ba	ajaj /	Allia	an
I hereby declare that the concealment of any mat General Insurance Comp claim is made. I hereby d Date: O O M M M T	terial fac pany Lin eclare ti	et with nited, I nat I ha	respe o seek ve inc	ct to enece lude	que: essar d all t	ry m the b	ns asl edica pills /	rece	in reform	fort	n to n / d he p	this locul urpo	clai mer	m, m	of n y rig	ny ki ht to ny h	nowl o cla ospi	edg im re	e ar eim Med I no	nd be	elief. eme Prae maki	If II	shal one any	l be r wh supp	for no h pler	feite na s mer	ed. atte	als nde y cla	o co	ons on th	ent he p	& a	uth	oriz	e Ba	ajaj /	Allia	an
I hereby declare that the concealment of any mat General Insurance Compclaim is made. I hereby d Date: O O M M M 7  Place: PLEASE COMPL	terial factorial	et with nited, that I ha	respe o seek ve inc	ct to enece lude	quesessard all t	AN DENT	ns asl edica pills /	YC REAT	ormeipts  OUR	latio natio for t	on to on / o he p	this locul urpo	clai mer ose o	m, m	of n y rig om a clai	ny ki ht to ny h m &	nowl c cla ospi that	edg im re	e ar eim Med I no	od be burs dical	elief. Pradmaki	If II  Left ing	shal one any:	l be r wh supp	for no h pler	feite na s mer	ed. attentar	alsonde y cla re o	o co ed o aim	ons on the	ent he p	& a ers	on a	oriz	e Ba	ajaj /	Allia	an
I hereby declare that the concealment of any mat General Insurance Compclaim is made. I hereby d Date: D D M M V Place:  PLEASE COMPL  MEDICAL EXPENSES	terial factorial	et with nited, that I ha HE SE	respe to seek ve inc	ct to necelludes	essard all t	AN DENT	ns asl edica pills /	YC REAT	our MEN	CL,	AIM	this locul urpo	clai mer ose o	m, m nts fro of this	of n y rig om a clai	ny ki ht to ny h m &	nowl c cla ospi that	edg im re	e arreim Med I no	nd be burs dical	elief. Pradmaki	If II  If II  ctititing  VACCEREE	shal one any:	l be r wh supp	for no h pler	feite na s mer	ed. attentar	alsonde nde y cla	o coded of aim	onson the	ent he p	& a ers	N D	oriz	e Ba	ajaj / who	Allia	an
I hereby declare that the concealment of any mat General Insurance Compclaim is made. I hereby d Date: O O M M T Place:  PLEASE COMPL  MEDICAL EXPENSES  MATERNITY AND BAE  CANCER SCREENING.  Name & Address of	terial factorial	et with nited, that I ha HE SE	respe to seek ve inc	ct to necelludes	essard all t	AN DENT	ns asl edica pills /	YC REAT	our MEN	CL,	AIM	this locul urpo	clai mer ose o	m, m nts fro of this	of n y rig om a clai	ny ki ht to ny h m &	nowl c cla ospi that	edg im re	e arreim Med I no	and be burs dical to be r	elief. Pradmaki	If II  If II  ctititing  VACCEREE	shal one any:	l be r wh supp	for no h pler	feite na s mer	ed. latte	alsonde nde y cla	o coded of aim	onson the	ent he p	& a ers	N D	oriz	e Ba	ajaj / who	Allia	an
I hereby declare that the concealment of any mat General Insurance Comp claim is made. I hereby d Date: O DATE O D	terial factorial	et with nited, that I ha HE SE	respe to seek ve inc	ct to necelludes	essard all t	AN DENT	ns asl edica pills /	YC REAT	our MEN	CL,	AIM	this locul urpo	clai mer ose o	m, m nts fro of this	of n y rig om a clai	ny ki ht to ny h m &	nowl c cla ospi that	edg im re	e arreim Med I no	and be burs dical to be r	elief. Pradmaki	If II  If II  ctititing  VACCEREE	shal one any	l be r wh supp	for no h pler	feite na s mer	ed. latte	alsonde nde y cla	o coded of aim	onson the	ent he p	& a ers	N D	oriz	e Ba	ajaj / who	Allia	an
I hereby declare that the concealment of any mat General Insurance Compclaim is made. I hereby d Date: D D M M T Place:  PLEASE COMPL  MEDICAL EXPENSES  MATERNITY AND BAE  CANCER SCREENING AND AND ADDRESS OF OVERSES CONSUlting	terial factorial	et with nited, that I ha HE SE	respe to seek ve inc	ct to necellude	essard all t	AN DENT	ns asl edica pills /	YC REAT	our MEN	CL,	AIM	this locul urpo	clai mer ose o	m, m nts fro of this	of m y rig	ny ki ht to ny h m &	nowl c cla ospi that	edg im re	e arreim Med I no	and be burs dical to be r	elief. Pradmaki	If II  If II  ctititing  VACCEREE	shal one any	l be r wh supp	for no h pler	feite na s mer	ed. latte	alsonde nde y cla	o coded of aim	onson the	ent he p	& a ers	N D	oriz	e Ba	ajaj / who	Allia	an
I hereby declare that the concealment of any mat General Insurance Compclaim is made. I hereby d Date: O O M M Y Place:  PLEASE COMPL  MEDICAL EXPENSES  MATERNITY AND BAB  CANCER SCREENING OVERSEAS CONSUlting physician	terial factorial	et with nited, that I ha HE SE	respe to seek ve inc	ct to necellude	essard all t	AN DENT	ns asl edica pills /	YC REAT	DUR EMEN SS AI	CL/	AIM	this loculurpo	clai mer ose o	m, m, mts fro	of m y rig	ny ki ht to ny h m &	nowl c cla ospi that	edg im re	e arreim Med I no	and be burs dical to be r	elief. Pradmaki	If II  If II  ctititing  VACCEREE	shal one any	l be r wh supp	for no h	feite na s mer	ed. latte ntar	alsonde nde y cla	o coded of aim	onson the	ent he p	& a sers	N D	oriz	e Ba	ajaj / who	Allia	an
I hereby declare that the concealment of any mat General Insurance Compclaim is made. I hereby d Date: O DATE:	terial factorial	et with nited, that I ha HE SE	respe to seek ve inc	ct to necellude	essard all t	AN DENT	ns asl edica pills /	YC REAT	DUR EMEN SS AI	CL/	AIM ALCO	this loculurpo	clai mer ose o	m, m, mts fro	of m y rig	ny ki ht to ny h m &	nowl c cla ospi that	edg im re	e arreim Med I no	and be burs dical to be r	elief. Pradmaki	If II  Let It II  Let It II  Let II  L	shal one any	l be r wh supp	for no h	feite na s i mer	ed. latte ntar	alsonde nde y cla	o coded of aim	onson the	ent he p	& a sers	N D	oriz	e Ba	ajaj / who	Allia	an
I hereby declare that the concealment of any mat General Insurance Compclaim is made. I hereby declare is made. I hereby d	ETE THE	HE SEC	respe o seek ve inc	ct to c necoluded	LEV N	AN DENT MENT MEDI	ns asl edica pills /	YC REAT	DUR EMEN SS AI	CL/	AIM ALCO N	this loculurpo	clai mer ose o	m, m, mts fro	of m y rig	ny ki ht to ny h m &	nowl c cla ospi that	edg im re	e arreim Med I no	and be burs dical to be r	elief. Pradmaki	If II  Let It II  Let It II  Let II  L	shal one any	l be r wh supp	for no h	feite na s i mer	ed. latte ntar	alsonde nde y cla	o coded of aim	onson the	ent he p	& a sers	N D	oriz	e Ba	ajaj / who	Allia	an
I hereby declare that the concealment of any mat General Insurance Compclaim is made. I hereby declare is made. I hereby d	ETE THE	HE SEC	respe o seek ve inc	ct to c necoluded	LEV N	AN DENT MENT MEDI	ns asl edica pills /	YC REAT	DUR EMEN SS AI	CL/	AIM ALCO N	this loculurpo	clai mer ose o	m, m, mts fro	of m y rig	ny ki ht to ny h m &	nowl c cla ospi that	edg im re	e arreim Med I no	and be burs dical to be r	elief. Pradmaki	If II  Let It II  Let It II  Let II  L	shal one any:	l be r wh supp	for no h	feite na s i mer	ed. latte ntar	alsonde nde y cla	o coded of aim	onson the	ent he p	& a sers	N D	oriz	e Ba	ajaj / who	Allia	an
I hereby declare that the concealment of any mat General Insurance Compclaim is made. I hereby declare is made. I hereby d	ETE THE	HE SEC	respe o seek ve inc	ct to c necoluded	LEV N	AN DENT MENT MEDI	ns asl edica pills /	YC REAT	DUR EMEN SS AI	CL/	AIM ALCO N	this loculurpo	clai mer ose o	m, m, mts fro	of my rigg	ny ki ht to ny h m &	nowl c cla ospi that	edg im re	e arreim Med I no	and be burs dical to be r	elief. Pradmaki	If II  Let It II  Let It II  Let II  L	shal one any:	l be r wh supp	for no h	feite na s i mer	ed. latte ntar	alsonde nde y cla	o coded of aim	onson the	nsur LIZA	& a sers	N D	oriz	e Ba	ajaj / who	Allia	an
I hereby declare that the concealment of any mat General Insurance Compclaim is made. I hereby d Date: D D M M T T DATE: D D M M T T DATE: D D M M T T DATE: D DATE: D D M M T T DATE: D DATE:	ETE THE	HE SEC	respe o seek ve inc	ct to c necoluded	LEV N	AN DENT MENT MEDI	ns asl edica pills /	YC REAT	DUR EMEN SS AI	CL/	AIM	this idea with the control of the co	clai mer ose o	m, m, mnts from fithis from fithis state of this state of	of my rigg	ny ki ht to ny h m &	nowl c cla ospi that	edg im re	e arreim Med I no	and be burs dical to be r	elief. Pradmaki	If II  Let It II  Let It II  Let II  L	shal one any:	l be r wh supp	for no h	feite na s i mer	ed. latte htar	alsonde nde y cla	o coded of aim	onson the	nsur LIZA	& asers	N D	oriz	e Ba	ajaj / who	Allia	an
I hereby declare that the concealment of any mat General Insurance Compclaim is made. I hereby d Date: D D M M T T DATE: D D M M T T DATE: D D M M T T DATE: D DATE: D D M M T T DATE: D DATE:	ETE THE	HE SEC	respe o seek ve inc	ct to c necoluded	LEV N	AN DENT MENT MEDI	ns asl edica pills /	YC REAT	DUR EMEN SS AI	CL/NT ND A TION E-	AIM ALCO N Inne (F	this idea with the control of the co	clai mer ose o	m, m, mnts from fithis from fithis state of this state of	of my rigg	ny ki ht to ny h m &	nowl c cla ospi that	edg im re	e arreim Med I no	and be burs dical to be r	elief. Pradmaki	If II  Let It II  Let It II  Let II  L	shal one any:	l be r wh supp	for no h	feite as a simmer	ed. latte htar	alsonde nde y cla	o coded of aim	onson the	nsur LIZA	& asers	N D	oriz	e Ba	ajaj / who	Allia	an
I hereby declare that the concealment of any mat General Insurance Comp claim is made. I hereby d Date: O DATE	ETE THE	HE SEC	respe o seek ve inc	ct to c necoluded	LEV N	AN DENT MENT MEDI	ns asl edica pills /	YC REAT	DUR EMEN SS AI	CL/NT ND A TION E-	AIM	this idea with the control of the co	clai mer ose o	m, m, mnts from fithis from fithis state of this state of	of my rigg	ny ki ht to ny h m &	nowl c cla ospi that	edg im re	e arreim Med I no	and be burs dical to be r	elief. Pradmaki	If II  Let It II  Let It II  Let II  L	shal one any:	l be r wh supp	for no h	feite as a simmer	ed. latte htar	alsonde nde y cla	o coded of aim	onson the	nsur LIZA	& asers	N D	oriz	e Ba	ajaj / who	Allia	an
I hereby declare that the concealment of any mat General Insurance Compclaim is made. I hereby declare is made. I hereby d	ETE THE	HE SEC	respe o seek ve inc	ct to c necoluded	LEV N	AN DENT MENT MEDI	ns asl edica pills /	YC REAT	DUR EMEN SS AI	CL/NT ND A TION E-	AIM ALCO N Inne (F	this idea with the control of the co	clai mer ose o	m, m, mnts from fithis from fithis state of this state of	of my rigg	ny ki ht to ny h m &	nowl c cla ospi that	edg im re	e arreim Med I no	and be burs dical to be r	elief. Pradmaki	If II  Let It II  Let It II  Let II  L	shal one any:	l be r wh supp	for no h	feite as a simmer	ed. latte htar	alsonde nde y cla	o coded of aim	onson the	nsur LIZA	& asers	N D	oriz	e Ba	ajaj / who	Allia	an
I hereby declare that the concealment of any mat General Insurance Compclaim is made. I hereby d Date: D D M M T T Place:  PLEASE COMPL  MEDICAL EXPENSES  MATERNITY AND BABE  CANCER SCREENING Overseas consulting physician  City  Phone (O)  Fax  Have you ever been treated flyes, provide name & address of consulted physician  City  Phone (O)  Fax  Provide name & address of your family physician:	ETE THE	HE SEC	respe o seek ve inc	ct to c necoluded	LEV N	AN DENT MENT MEDI	ns asl edica pills /	YC REAT	DUR EMEN SS AI	CL/NT ND A TION E-	AIM ALCO N Inne (F	this idea with the control of the co	clai mer ose o	m, m, mts from the first from the fi	of n y rig	ny ki ht to ny h m &	nowl c cla ospi that	edg im re	e arreim Med I no	and be burs dical to be r	elief. Pradmaki	If II  Let It II  Let It II  Let II  L	shal one any:	l be r wh supp	for no h	feite as a simmer	ed. latte htar	alsonde nde y cla	o coded of aim	onson the	ent he p	ers red	N D	oriz	e Ba	ajaj / who	Allia	an
I hereby declare that the concealment of any mat General Insurance Compclaim is made. I hereby declare is made. I hereby d	ETE THE	HE SEC	respe o seek ve inc	ct to c necoluded	LEV N	AN DENT MENT MEDI	ns asl edica pills /	YC REAT	DUR EMEN SS AI	CL/	AIM ALCO N Inne (F	this loculurped the thing	clai mer ose o	m, m, mnts from fithis from fithis state of this state of	of n y rig	ny ki ht to ny h m &	nowl c cla ospi that	edg im re	e arreim Med I no	and be burs dical to be r	elief. Pradmaki	If II  Let It II  Let It II  Let II  L	shal one any:	l be r wh supp	s s	feite as a simmer	ed. latte htar	alsonde nde y cla	o coded of aim	onson the	ent he p	& asers	N D	oriz	e Ba	ajaj / who	Allia	an

Diament.					
Diagnosis if sickness-state nature of diagnosis and advise when and where symptoms first occurred	d				
Kindly confirm nature of Injury: Self Inflicted  Accident	u				
Substance Abuse/Alcohol Consumption at the time of accident Yes No					
If Accident kindly confirm how where and when it happened				Million State State State	
Kindly confirm if accident reported to Police Station Yes No(If yes Kindly attack	ched FIR copy)	Sent 4 3547 6 -			
Treatment Taken OutpatientInpatientInpatient					
Treatment Type- Medical - Yes No or Surgical - Yes No	The state of the state of				
Kindly Provide name and address of diagnostic center in India where regular health chec	rkun/investigati	ons 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	ber & certificate	number of insurer			
DETAILS OF MEDICAL EXPENSES			TANKE AND DESCRIPTION OF THE PARTY OF THE PA	THE PROPERTY OF THE PARTY OF TH	
DETAILS OF MILDICAL LAFENSES			STATE OF THE PARTY	SEASTERNAME OF THE PROPERTY OF	AND DESCRIPTION OF DESCRIPTION
Details of treatment	In/Ou	ut Patient	CI	narges (Currency)	Status of Payment
	From	То		Eg : USD / EURO	Paid/Outstanding
	110	-		-57	
					De la constitución de la constit
		N. Salakara		8	
				Paid	
				Outstanding	
				TOTAL	
LOSS /DELAY OF CHECKED BAGGAGE					
Describe when & where the loss/delay took place :					
Describe when a where the loss/ acity took place.					
	Namethe	airline:			The state of the s
State the extent of Loss:				_Fromto	
1. Flight Noto					
	ice No				
Details of compensation received from airline:					
Scheduled date/time of Arrival: D D M M Y Y Y Y H hrs.					
Actual date/time when bags delivered D D M M Y Y Y Y hrs.	No. of	Hours delayed :	h	rs.	
Item Purchased/Lost *		Date of Purc	hase	Place	Cost
item Fulchased/Lost		Dute of Fare	nuse		
The control of the state of the		A Landerson			
The state of the s					
				TOTAL	
				TOTAL	
Less Compensation received from Airlin	ne:				
			100	Net Amount	
*In case of Delay, please provide details of purchases made , *In case of Loss, please prov	vide details of it	ems lost.	icati Le		
	NAME AND POST OFFICE ADDRESS OF THE PARTY OF	North Alberta Williams	ENGLISHER	ENCORPORA DE LA COMPANSION DEL COMPANSION DE LA COMPANSION DE LA COMPANSION DE LA COMPANSIO	
LOSS OF PASSPORT			4,52,64	<b>图</b>	NAME OF TAXABLE PARTY.
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 Place:	
		Data		Place	Amount
Details of Expense/Loss Incurred*		Date		PidCe	Amount
		- G - Har 1			
				TOTAL	
TOIR DELAY		Been water trade made	THE REPORT		PRESIDENT PERSONAL PROPERTY.
TRIP DELAY	A CONTRACTOR	S SALES OF THE BOTTOM	College Strategy		
Flight No. Date D D M M Y Y Y Y From 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 delay	yed:	hrs.			
Reason for trip delay:					
				DI.	Δ=
Details of Expense Incurred		Date		Place	Amount
				TOTAL	

TRIP CANCELLATION/ /TRIP CURTAILMENT			
Flight No. Date D D M M Y Y Y Y From From	_to		
Scheduled time of Departure: hrs. Reason for Cancellation//Curtailr	nent:		
Details of Expense Incurred	Date	Place	Amount
Amount refunded by Common Carrier and Hotel			
		TOTAL	
PERSONAL LIABILITY			
Please provide details of injury/property damaged			MEDICE POLICIANA PROPERTY ST
Have you received a court order, if Yes, please furnish a copy	No		
EMERGENCY HOTEL ACCOMMODATION FOR FAMILY MEMBER/ EMERGENC	HOTEL EXTENSION		
Please provide details of the emergency incident			
F			
Details of Expense Incurred*	Date	Place	Amount
		8	
		TOTAL	
MISSED CONNECTION			
Flight No. Date D D M M V V V Y From	_to		
Actual date/time of departure D D M M Y Y Y Y hrs. No. of Hours d	elayed: hrs.	Yes No	
HIJACK		The state states a said plane.	
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.           Scheduled date/time of Arrival:         D         D         M         M         Y         Y         Y         Y         Y         Hrs.	Date & time of Hijack	D M M Y Y Y Y	hrs.
Scheduled date/time of Arrival: D D M M V V V V V D hrs.  Please provide details of incident:	Date & time of Returned	D D M M Y Y Y Y	hrs.
FAMILY VISIT/ COMPASSIONATE VISIT/ REPLACEMENT AND REARRANGEME	NT OF STAFF/MINOR F	SCORT/TUTION FEES	
Kindly provide details of incident	VI OI STAIT/WIINORE	SCOKT/TOTIONTEES	
Kindiy provide detailsor incident			
Details of Expense/Loss Incurred*	Date	Place	Amount
Details of Expense/Loss incurred*	Date	Place	Amount
Details of Expense/Loss incurred*	Date	Place	Amount
Details of Expense/Loss incurred*	Date		Amount
Details of Expense/Loss incurred*	Date	Place	Amount
BAIL BOND/LOSS OF LAPTOP/HOME BURGLARY/LOSS OF PERSONAL BELON		TOTAL	Amount
		TOTAL	Amount
BAIL BOND/LOSS OF LAPTOP/HOME BURGLARY/LOSS OF PERSONAL BELON Please provide details of the incident i.e. when, where and how it happened:		TOTAL	Amount
BAIL BOND/LOSS OF LAPTOP/HOME BURGLARY/LOSS OF PERSONAL BELON Please provide details of the incident i.e. when, where and how it happened:		TOTAL	Amount
BAIL BOND/LOSS OF LAPTOP/HOME BURGLARY/LOSS OF PERSONAL BELON Please provide details of the incident i.e. when, where and how it happened:  Details of Police Report (please attach copy): No:	GINGS//EMERGENCY (	TOTAL  CASH ADVANCE  Y Place:	
BAIL BOND/LOSS OF LAPTOP/HOME BURGLARY/LOSS OF PERSONAL BELON Please provide details of the incident i.e. when, where and how it happened:	GINGS//EMERGENCY (	TOTAL EASH ADVANCE	Amount
BAIL BOND/LOSS OF LAPTOP/HOME BURGLARY/LOSS OF PERSONAL BELON Please provide details of the incident i.e. when, where and how it happened:  Details of Police Report (please attach copy): No:  D	GINGS//EMERGENCY (	TOTAL  CASH ADVANCE  Y Place:	
BAIL BOND/LOSS OF LAPTOP/HOME BURGLARY/LOSS OF PERSONAL BELON Please provide details of the incident i.e. when, where and how it happened:  Details of Police Report (please attach copy): No:  D	GINGS//EMERGENCY (	TOTAL  CASH ADVANCE  Y Place:	
BAIL BOND/LOSS OF LAPTOP/HOME BURGLARY/LOSS OF PERSONAL BELON Please provide details of the incident i.e. when, where and how it happened:  Details of Police Report (please attach copy): No:  D	GINGS//EMERGENCY (	TOTAL  CASH ADVANCE  Place:  Place	
BAIL BOND/LOSS OF LAPTOP/HOME BURGLARY/LOSS OF PERSONAL BELON Please provide details of the incident i.e. when, where and how it happened:  Details of Police Report (please attach copy): No:  D	GINGS//EMERGENCY (	TOTAL  CASH ADVANCE  Y Place:	
BAIL BOND/LOSS OF LAPTOP/HOME BURGLARY/LOSS OF PERSONAL BELON Please provide details of the incident i.e. when, where and how it happened:  Details of Police Report (please attach copy): No:  Details of Expense/Loss Incurred*  I declare that the above answers are true and correct to the best of my knowledge and that I have	GINGS//EMERGENCY (  ate: D D M M Y Y Y  Date  e not withheld any relevan	TOTAL  ASH ADVANCE    Y   Place:   Place  TOTAL  t information which might has	Amount  ave otherwise affected the
BAIL BOND/LOSS OF LAPTOP/HOME BURGLARY/LOSS OF PERSONAL BELON Please provide details of the incident i.e. when, where and how it happened:  Details of Police Report (please attach copy): No:  Details of Expense/Loss Incurred*  I declare that the above answers are true and correct to the best of my knowledge and that I hav acceptance of my application. I understand and agree that the insurance applied for will become	GINGS//EMERGENCY (  ate: D D M M Y Y Y  Date  e not withheld any relevan	TOTAL  ASH ADVANCE    Y   Place:   Place  TOTAL  t information which might has	Amount  ave otherwise affected the
BAIL BOND/LOSS OF LAPTOP/HOME BURGLARY/LOSS OF PERSONAL BELON Please provide details of the incident i.e. when, where and how it happened:  Details of Police Report (please attach copy): No:  Details of Expense/Loss Incurred*  I declare that the above answers are true and correct to the best of my knowledge and that I have	GINGS//EMERGENCY (  ate: D D M M Y Y Y  Date  e not withheld any relevan	TOTAL  ASH ADVANCE    Y   Place:   Place  TOTAL  t information which might has	Amount  ave otherwise affected the
BAIL BOND/LOSS OF LAPTOP/HOME BURGLARY/LOSS OF PERSONAL BELON Please provide details of the incident i.e. when, where and how it happened:  Details of Police Report (please attach copy): No:  Details of Expense/Loss Incurred*  I declare that the above answers are true and correct to the best of my knowledge and that I hav acceptance of my application. I understand and agree that the insurance applied for will become paid.	GINGS//EMERGENCY (  ate: D D M M Y Y Y  Date  e not withheld any relevan	TOTAL  ASH ADVANCE    Y   Place:   Place  TOTAL  t information which might has	Amount  ave otherwise affected the
BAIL BOND/LOSS OF LAPTOP/HOME BURGLARY/LOSS OF PERSONAL BELON Please provide details of the incident i.e. when, where and how it happened:	GINGS//EMERGENCY (  ate: D D M M Y Y Y  Date  e not withheld any relevan	TOTAL  ASH ADVANCE    Y   Place:   Place  TOTAL  t information which might has	Amount  ave otherwise affected the
BAIL BOND/LOSS OF LAPTOP/HOME BURGLARY/LOSS OF PERSONAL BELON Please provide details of the incident i.e. when, where and how it happened:  Details of Police Report (please attach copy): No:  Details of Expense/Loss Incurred*  I declare that the above answers are true and correct to the best of my knowledge and that I hav acceptance of my application. I understand and agree that the insurance applied for will become paid.	GINGS//EMERGENCY (  ate: D D M M Y Y Y  Date  e not withheld any relevan	TOTAL  ASH ADVANCE    Y   Place:   Place  TOTAL  t information which might has	Amount  ave otherwise affected the premium being fully

## Bajaj Allianz General Insurance Company Limited



Ground Floor, 32/2 Ashoka Plaza, Next to Weikfield Company, Nagar Road, Pune - 411014. Phone No.: +912030305858, 1800225858, 18001025858

	ATTENDING PHYS	ICIANS STATEMENT			
atient's Name :			Age :	Sex:	M/F
ate of first consultation :		Time:			
	For Acci	Time:dental Injury			
lature of Injury :	*				
K-Ray Taken: Yes	No Date tal	ken:			
are the injuries solely due to the Please mention past history with	e accident or traceable to any previous inju n duration of any diseases, accidents or hosp	ries / disease pitalizations with details :			
Was he under the influence of in	ntoxicants / alcohol or drugs at the time of				
	For	Sickness			
Nature of Illness :					
History of Presenting complaint	s:				
Diagnosis and Treatment Given	:		×		
		4			
	rst manifest: h duration of any diseases, accidents or hos				
				No.	
History of the following :- Ailment	Yes / No, If yes Duration	Ailment	Y	es / No, If yes	Duration
Hypertension	100 / 110, 11 /00 001 00101	Diabetes			
Cardiac ailments		Asthma			
Arthritis		Cancer			
Is this claimant Totally Disable How long would the claiman How long would the claima Prognosis of the ailment/injury	nt be partially disabled ? ::				
Signature:At	tending Doctor's Signature and Stam		Reg. No.:		
Doctor's Name:					
Address & Phone No.:					



Authorization for medical records/pat	ient informatio	n		
Patient Name:			Date of Birth:	
Patient Address:			Patient Accoun	t #:
Patient's Allianz Global Assistance case	#:		DOS:	
I hereby authorize the Medical Records release information from my medical rec	Department state cords to:	ff at		(Facility/Physician name) to
Allianz Global Assistance PO Box 71987, Richmond, VA 23255	- 1987	Telephone: 51 Email: MGCC-	9 741 0429 NA-CM@allianz	Fax: 519 742 8720 z-assistance.ca
For the purpose of: (Please check all the	at apply)			
Continued Treatment Personal review of information	Legal Revie Other (Plea	ew se specify)	Insurance p	ourpose
I limit the information to be released to t	he following iten	ns: (Please chec	k all that apply)	
All Pertinent Records Discharge Summary Operative Report Dental Report	Consultatio Emergency Other (Plea	n Dept Report se Specify)	Diagnostic	test (eg. Lab, x-ray, radiology) Physical
I understand that this authorization will adjudicate my claims. I am aware that r my insurance claims.	allow Allianz Glo efusal to release	obal Assistance to e all or any of the	o use the inform information liste	ation obtained to investigate and ed above could result in denial of
I understand that medical records may assistance services by Allianz Global A	be disclosed to essistance.	certain third parti	es for insurance	adjudication purposes and
I understand that I can revoke this auth the extent that action has already been	orization at any taken on this au	time by contactinuthorization.	ng Allianz Global	Assistance in writing, except to
I understand that the information discloinformation if that applies to me; my sig releasing information related to:	nature authorize	es the release of	n may include ps any such inform ntal Health	ation I do not consent to
Unless I revoke this authorization earlie	er, it will expire	1 year from the	date signed or	as specified:
Signature of Patient/Legal Representat	ive		Date:	
If other than patient, relationship to pati	ient		Witne	ss:

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

o Bajaj Allianz General Insurano	ce Company		Code & I		#1/a-1/4		
artner ID (To be filled by Office):					T		T
artion to thousand by emesy.							
ull Name:	Shri / Smt / Ki (As appears i	um / M/s in your bank	account)		********		
ull Address:				500.0			
contact / Mobile No:	Dest Politica des	Email ID	NEW YORK OF THE PERSON NAMED IN	PIN C	ode:		
Bank Name:							
Branch Name & Address:							
Branch Tel No & Contact No:							
Branch IFSC Code for NEFT		U STATE OF	100	ET LESS			
Branch MICR Code							
Name of the Account Holder : (As per Bank Account)							
Account Type	Saving	s	Cur	rent	Cas	sh Credit	
Account No. (as appearing in the cheque book)							
we have read the declarations / co				gnature)			
	MANDA	TORY RE	QUIREME	<u>ENT</u>			
	PLE/	ASE ATTA	CH HERE				
Cancelled blank Cheque of your ba IFSC code. If NAME OR IFSC code of of the bank passbook also.	nk for ensuring of the payee is I	accuracy of not printed o	name of the	he bank, branch jue leaf, please a	name, Ac	count nui	mber and
I have verified the documents attached Partner Name mentioned in the mandate	with the mandate	and confirm by superior)	that these do	ocuments correctly	y belong to	the Partne	er ID &
Employee Code Employ	ee Name:			Designation	on		
Place Da	ate	Signatur	e				