

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

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	<input type="text"/>		
Name of the Employee	<input type="text"/>		
Name of the Claimant	<input type="text"/>		
Phone Nos Overseas	<input type="text"/>		
Permanent Address	<input type="text"/>		
City	<input type="text"/>	State <input type="text"/>	PIN <input type="text"/>
Phone (O)	<input type="text"/>	Phone (R) <input type="text"/>	Mobile <input type="text"/>
Fax	<input type="text"/>	E-mail <input type="text"/>	
Date of Birth	<input type="text"/>	Passport No.	<input type="text"/>
Date of Departure	<input type="text"/>	Flight No.	<input type="text"/>
Date of Arrival	<input type="text"/>	Flight No.	<input type="text"/>

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 General Insurance Limited, to seek necessary medical information / documents from any hospital / Medical Practitioner who has 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:

Place: _____ Signature of the Insured

PLEASE COMPLETE THE SECTION RELEVANT TO YOUR CLAIM

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> MEDICAL EXPENSES | <input type="checkbox"/> DENTAL TREATMENT | <input type="checkbox"/> MEDICAL EVACUATION | <input type="checkbox"/> HIV |
| <input type="checkbox"/> MATERNITY AND BABY COVER | <input type="checkbox"/> MENTAL ILLNESS AND ALCOHOL RELATED DISORDER | <input type="checkbox"/> CANCER SCREENING | <input type="checkbox"/> HOSPITALIZATION DAILY ALLOWANCE |
| <input type="checkbox"/> CANCER SCREENING AND MAMMOGRAPHY | <input type="checkbox"/> MEDICAL REPATRIATION | <input type="checkbox"/> PRE EXISTING ILLNESS | <input type="checkbox"/> 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

TRIP CANCELLATION/ /TRIP CURTAILMENT

Flight No. _____ Date From _____ to _____

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

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 From _____ to _____

Actual date/time of departure hrs. No. of Hours delayed : hrs. Yes No

HIJACK

Flight No. _____ Date From _____ to _____

Scheduled date/time of Departure: hrs. Date & time of Hijack hrs.

Scheduled date/time of Arrival: hrs. Date & time of Returned 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: 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:

Place: _____

X

Signature

Bajaj General Insurance Limited

(Formerly known as Bajaj Allianz General Insurance Co. Ltd.)

Bajaj Insurance House, Airport Road, Yerawada, Pune - 411006. IRDAI Reg No.: 113. | CIN: U66010PN2000PLC015329

E-mail: careforyou@bajajgeneral.com | www.bajajgeneralinsurance.com



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

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 : X _____ Date : _____ Reg. No. : _____

Attending Doctor's Signature and Stamp

Doctor's Name :

Address & Phone No. :



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 Telephone: 519 741 0429 Fax: 519 742 8720
PO Box 71987, Richmond, VA 23255 - 1987 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 Consultation Diagnostic test (eg. Lab, x-ray, radiology)
- Discharge Summary Emergency Dept Report History and Physical
- Operative Report Other (Please Specify) _____
- Dental Report

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 General Insurance Limited (Formerly known as Bajaj Allianz General Insurance Co. Ltd.)	Office Code & Name : i-track Number :
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Partner ID *(To be filled by Office)*:

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

Full Address: _____

Contact / Mobile No: _____ PIN Code: _____

_____ 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 _____

DECLARATION

- I / We hereby declare that the particulars given above are correct and complete and no blanks have been left. If the transaction is delayed or not effected at all for reason of incomplete or incorrect information I / we would not hold Bajaj General Insurance Limited responsible.
- I / We undertake to revoke the instruction for NEFT in the event of the business relationship expiring and or being 'terminated' and further hereby specifically authorize Bajaj General Insurance Limited, to do so, for me and on my behalf, in case the revocation communication is not received from me within seven days of expiry and or being termination of relationship.
- I / We further undertake to refund, at any time, any excess amount whether demanded by Bajaj General Insurance Limited or not, which has been credited to my account [due to any reason] by Bajaj General Insurance Limited, in excess of (i) the amount due to me, or (ii) in excess of amount for which I gave mandate, and or (iii) agreed rent/license fees/compensation/refundable security deposit/Commission/Claim/Refund/ Any other payment.
- I / We agree that the payment will be endeavoured to be credited starting from the date of next payment cycle and unless the Mandate is revoked by me/us issuance of relevant credit instruction for electronic payment from Bajaj General Insurance Limited into the aforesaid account will be valid discharge to Bajaj General Insurance Limited for having paid (i) the amount due to me, or (ii) in excess of amount for which I gave mandate, and or (iii) agreed rent/license fees/compensation/refundable security deposit/ Commission/Claim/Refund/Any other payment.
- I / We further confirm that we understand this mode as a method of payment introduced by Reserve Bank of India, which provides us an option to receive the amount and or to collect our payments by electronic payment mode directly through my/our bank accounts.
- I / We further confirm that I/we understand, Bajaj General Insurance Limited, shall make electronic payment to my account by issuing the Payment instruction electronically through its banker to the Clearing Authority and the Clearing Authority would ensure credit to my/our specified bank account provided hereinabove.
- I / We further undertake to inform Bajaj General Insurance Limited with an advance notice of 6 weeks, to withdraw from this mode of electronic payment.
- I / We further confirm that Bajaj General Insurance Limited will have, at its sole discretion, the right to return back to the option of paying to me/us by way of cheque if there are more than 2 consecutive failures in remittances for no fault on the side of Bajaj General Insurance Limited.
- After Bajaj General Insurance Limited issuing the Payment instruction electronically through its banker, for whatever reasons, if I/we do not get the credit to my/our account, then same shall neither constitute the default in (i) Payment of amount requested by me, or (ii) Payment of amount due to me/us, or (iii) Payment of agreed rent/license fees/compensation/refundable security deposit/ commission/claim/ Refund/Any other payment by Bajaj General Insurance Limited nor constitute default of any terms and conditions of any agreement/MOU/ Claim/Refund/Other contract and or Lease agreement/Leave and license agreement with me/us.