Bajaj Allianz General Insurance Co. Ltd.

BAJAJ | Allianz

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