

Reliance Travel Care Insurance Policy

Claim Form

The issue of this form does not constitute admission of liability. Please return the form completed within Fourteen days of the loss together with the relevant vouchers, documents etc.

PLEASE ANSWER EVERY QUESTION FULLY

1. Name of the Insured:							
2. Address of the Insured:	Plot No/Door No.		Building Name				
	Road						
	Area						
	City		Pin code				
	State						
	Phone No.	STD		-			
	Mobile No.						
E-mail Id							
3. Personal Details							
a) Name of the Insured /Insured person: _____ (in respect of whom the claim is made)							
b) Present completed age: _____							
c) Occupation: _____							
4. Details of Policy:							
a) Policy Number _____							
b) Date of Issue _____							
c) Date of commencement of trip _____							
d) Number of Days _____							
e) Scheduled Date of Return _____							
f) Geographical Limits _____							
i) Worldwide Excl USA/CANADA (Please specify the country) _____							
ii) Worldwide Incl. USA / CANADA _____							
5. Policy Section Relating to Claim:							
a) AD & D Common Carrier	<input type="checkbox"/>	k) Medical Expenses	<input type="checkbox"/>				
b) Bail Bond	<input type="checkbox"/>	l) Missed Connection	<input type="checkbox"/>				
c) Compassionate Visit	<input type="checkbox"/>	m) Personal Accident	<input type="checkbox"/>				
d) Daily Allowance in case of Hospitalization	<input type="checkbox"/>	n) Personal Liability	<input type="checkbox"/>				
e) Delay of Checked Baggage	<input type="checkbox"/>	o) Repatriation of Remains	<input type="checkbox"/>				
f) Dental Treatment	<input type="checkbox"/>	p) Sponsor Protection	<input type="checkbox"/>				
g) Financial Emergency Assistance	<input type="checkbox"/>	q) Study Interruption	<input type="checkbox"/>				
h) Hijack Distress Allowance	<input type="checkbox"/>	r) Total Loss of checked Baggage	<input type="checkbox"/>				
i) Home Burglary Insurance	<input type="checkbox"/>	s) Trip Cancellation & Interruption	<input type="checkbox"/>				
j) Loss of Passport	<input type="checkbox"/>						
6. Date of injury sustained or disease/illness first detected		<input type="checkbox"/>	<input type="checkbox"/>	DD	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	MM	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	YY	<input type="checkbox"/>	<input type="checkbox"/>	

RELIANCE General Insurance

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7. Doctor's details			
a) Name & address of the attending medical practitioner _____ _____			
b) Qualification & telephone no _____			
c) Registration no. _____			
8. Name & address of the hospital/nursing home/clinic _____ _____			
9. Complaint logged with Service Provider details			
a) Complaint log number _____			
b) Date of complaint <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>			
c) Time of complaint <input type="text"/> <input type="text"/> H <input type="text"/> <input type="text"/> M			
d) Whether payment guarantee extended by the Service Provider		<input type="checkbox"/> Yes <input type="checkbox"/> No	
e) Hospitalization details:			
a) Date of admission <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
b) Date of discharge <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
f) If the claim is for domiciliary please indicate			
a) Name & address of attending medical practitioner _____ _____			
b) Telephone no. _____			
c) Registration no. _____			
d) Date of treatment <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
g) Schedule of expenses incurred by the claimant under hospitalization/domiciliary (to be supported by bills/receipts, cash memos etc.)			
	Expenses incurred in the hospital	Outside	Total
Hospitalization Benefit			
Domiciliary			
h) Incase of Repatriation of Remains			
a) Cause of Death _____			
b) Date of Death _____			
c) Death Certificate _____			

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I have incurred the above expenses for the treatment of the disease / illness / accident referred to here.

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.

Dated at _____ this day of _____ 200 .

Signature of the Claimant
