



WE KEEP YOU GOING

## **CLAIMS FORM FOR OVERSEAS TRAVEL INSURANCE**

Name of insured:
Every claim has to be accompanied with original ticket/boarding pass or copy of the passport indicating the travel dates.
MEDICAL EXPENSES
Name, address and telephone number of hospital / clinic where treatment was given:
Name of treating doctor:
Details of ailment:
Cause of the ailment:
Was the ailment / incident caused / aggravated due to a pre-existing condition? Please give details:
Date of onset of ailment: D D M M Y Y Y Y  Nature of treatment:
Dates of treatment: From DDMMMYYYYTODDMMMYYYYYIIIIIIIIIIIIIIIIIIIIIIIIIIIII
Claiming also for daily allowance

Sr. No.	Expense details	Amount
taken on differe	ent dates for seperate ailements will be treated as seperate medical claims, where standard deductible will apply for each claim.	
	Dental Treatment	
Name, address	and telephone number of hospital / clinic where treatment was given:	
Name of treating	and telephone number of hospital / clinic where treatment was given:  g dental surgeon:	
Name of treating	and telephone number of hospital / clinic where treatment was given:	
Name of treating Details of ailmer	and telephone number of hospital / clinic where treatment was given:  g dental surgeon:	
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Name of treating Details of ailmer  Cause of the ailn  Was the ailment	and telephone number of hospital / clinic where treatment was given:  g dental surgeon:  nt:  t/incident caused due to/aggravated due to a pre-existing condition? Please give details:  ailment:  D D M M Y Y Y Y	

Sr. No.	Expense details	Amount
	ormation given is just a summary report of the incident. Please attach more sheets to give details, if necessary. The claim form should be	
aken on differ	ment, along with prescriptions and original bills, and they must clearly show the medicines prescribed, price and the receipt stamp of the rent dates for seperate ailements will be treated as seperate medical claims, where standard deductible will apply for each claim.	ne pharmacy. Headi
	Repatriation of Remains	
	r:	
te of death o	of insured: DDDMMM YYYYY	
	of insured: DDMMYYYYYY	
		Amount
tails of expe	enses incurred for repatriation of remains/funeral:	Amount
tails of expe	enses incurred for repatriation of remains/funeral:	Amount
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Sr. No.	enses incurred for repatriation of remains/funeral:	
Sr. No.	Expense details  Expense details  Expense details  the Official death certificate and a Physician's statement for cause of death. Also, please attach the original bills/receipts of expense details	
Sr. No.	Expense details  Expense details	
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Sr. No.	Expense details  Expense details  Expense details  the Official death certificate and a Physician's statement for cause of death. Also, please attach the original bills/receipts of expense the Official death certificate and a Physician's statement for cause of death. Also, please attach the original bills/receipts of expense checked Baggage Loss	

Sr. No.	Description of items lost	Amoun
31. IVU.	Description of items lost	Amoun
	Checked Baggage Delay	
Date and Time of	Arrival Date: DDMMYYYY Time HHMM	1111
Date and Time of Port of Disembar		1 1 1 1
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	Loss of Passport	
late of Loss:	D D M M Y Y Y	
Place of Loss:		
xpenses inc	urred in obtaining new passport:	
Sr. No.	Expense details	Amount
Diagon attac	n the police report obtained within 24 hours of becoming aware of theft, and bills / vouchers of expenses incurred in obtaining a fresh / du	unlicate recensus Diseas
	Financial Emergency	
Date of Loss: Reason for los		
Please attac	the original police report filed within 24 hours of becoming aware of robbery. Please attach more sheets to give details, if necessary.	
	Personal Liability	
lame of the a	ggrieved Third party:	
	ggrieved Third party:	
Date of Loss: Place of loss:		
Date of Loss: Place of loss:	D D M M Y Y Y	
Date of Loss: Place of loss: Reason for los		
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Please atta  Cause of acci	DDMMYYYYY  I I I I I I I I I I I I I I I I I	

me of treating doctor:		
tes of medical / surgical treatment: From [ss incurred: (Please Tick)	D D M M Y Y	Y Y To D D M M Y Y Y Y
Death		
Loss or Inability to function of		
An arm at the shoulder joint: (Giv	ve Details)	
An arm below the elbow joint:	ive Details)	A head at the wrist: (Give Details)
A thumb: (Give Details)		An index finger: (Give Details)
Any other finger: (Give Details)		A leg above the centre of the femur: (Give Details)
A leg up to a joint below the fem		
A leg upto the centre of the tibia:		
A big toe: (Give Details)		Some other toe: (Give Details)
		(Civo Dotaile)
	scharge summary and they mus ails, if necessary. Please attach p	t mention, name of the person, cause of accident, details of medical treatment and dates
lease attach original bills/vouchers/reports/diseatment. Please attach more sheets to give detection t	Scharge summary and they musails, if necessary. Please attach particular and they musails, if necessary. Please attach particular and they musails, if necessary. Please attach particular and they musails and they musails and they musails are attach particular.	t mention, name of the person, cause of accident, details of medical treatment and dates
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Riot, Strike & Malicious Damage	ected of the same)
Bush Fire Storm, Cyclone, Typhoon, Tempest, Hurricane, Tornado, Flood & Inundat Bursting and / or overflowing of water tanks, apparatus and pipes  Exact description of Nature of loss and its causes (in case of burglary, how was forceful entry gained into the premises and who is suspended by whom was it discovered:  Cocupants of the premises at the time of Loss / by whom was it discovered:  Have the proper authorities (Fire Brigade & Police) been reported of the loss and by whom? Please give date of time of reporting (if not done, please)  Details of any other insurance cover for the property:  Details of Items Lost:	ected of the same)
Bursting and / or overflowing of water tanks, apparatus and pipes  Exact description of Nature of loss and its causes (in case of burglary, how was forceful entry gained into the premises and who is suspended by the premises at the time of Loss / by whom was it discovered:  Have the proper authorities (Fire Brigade & Police) been reported of the loss and by whom? Please give date of time of reporting (if not done, please)  Details of any other insurance cover for the property:  Details of Items Lost:	sected of the same)sected of the same)
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Occupants of the premises at the time of Loss / by whom was it discovered:	se give reasons):
Occupants of the premises at the time of Loss / by whom was it discovered:	se give reasons):
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Have the proper authorities (Fire Brigade & Police) been reported of the loss and by whom? Please give date of time of reporting (if not done, please)  Details of any other insurance cover for the property:  Details of Items Lost:	se give reasons):
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Sr. No.  Description of Items lost	
	Amou
The above information given is just a brief summary of the incident. Please attach more sheet to give details, if necessary. Please attach first i report by the police, fire brigade report, Invoices of owned articles (if required by the company), legal opinion wherever required.	information report, inves
Trip Cancellation & Interruption	
Trip Cancelled Trip Interrupted  Reason for trip cancelled / interrupted: (Tick one)	
Illness / Injury   Termination of Employment   Inclement Wea	
Loss to home Abduction / Quarantine Felonious Assa	ather
Terrorist Incident	

Insured	Family Member	Travelling Companion
If not the insured, then please	give the following details,	
Name of Person:		
Address of Correspondence: _		
		<u></u> -
City:	State:	Pin Code:
Relationship with Insured:		
Details of the reason for trip	Cancellation/Interruption (how, where and reasons for	the same):
Details of expenses:	France Joseph	
Sr. No.	Expense details	Amo
The above information given is	s iust a brief summary of the incident. Please attach more sh	neet to give details, if necessary. Please attach Medical reports and doctors
if trip is cancelled or interrupt	ed due to medical reasons. If due to employment reason,	then termination letter from the company shall be submitted. If due to oth or interruption is owing to the sickness, injury or death of a traveling comp
original tickets of the insured	I and the traveling companion indicating travel to the san	ne destination for the same dates needs to be submitted. All the bills / r
reasonable additional expensi	es incurred and/or proof of cancellation charges levied by the	; carriers snan de submitted.
Trip Dela	Y	
Reason for trip delay (Tick one)		
Illness / Injury	Termination of Employment	Inclement Weather
Loss to home	Abduction / Quarantine	Felonious Assault
Terrorist Incident	Delay by Carrier	Loss of passport, travel documents or money
Date & Time of Incident:	D M M Y Y Y Y Time H	H M M
Person Affected: (Tick one)	_	<u></u>
Insured	Family Member	Travelling Companion
If not the insured, then please	give the following details,	
Name of Person:		

	vith Person:	
Details of the	reason for trip delay (how, where and reasons for the same):	
Details of exp	enses:	
Sr. No.	Expense details	Amount
statement, of the insure	information given is just a brief summary of the incident. Please attach more sheet to give details, if necessary. Please attach Medic repolice report confirming the incident causing the trip delay. In case the delay is owing to the sickness, injury or death of a traveling compard and the traveling companion indicating travel to the same destination for the same dates needs to be submitted. Please also attach additional expenses incurred.	nion, the original tickets
	lissed Connections	
Actual Date &	Time of Arrival: D D M M Y Y Y Y Time H H M M  te & Time of Arrival: D D M M Y Y Y Y Time H H M M  f Departure for Connecting Flight: D D M M Y Y Y Y Time H H M M  ay:	
Details of exp	enses:	
Sr. No.	Expense Details	Amount

The above information given is just a brief summary of the incident. Please attach more sheet to give details, if necessary. Please attach confirmation from the airline, clearly mentioning the scheduled arrival time and the actual arrival time. The reason for delay in the flight also needs to be mentioned. All the bills / receipts of reasonable additional expenses incurred shall be submitted to the Company.

Name of Carrier / Hotel: II_I		
ooking Date: D D M	M Y Y Y	
onfirmation date: D D	M M Y Y Y	
eason for bounced booking:		
etails of additional expenses:		
Sr. No.	Expense Details	Amount
that confirmation was done of t	est a brief summary of the incident. Please attach more sheet to give details, if necessary. Ple he booking and was bounced due to overbooking. The tariff card / original booking confirr he original bills/receipts for the alternative accommodation/travel that were done also needs	mation indicating the cost of stay or travel,
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that confirmation was done of t cancellation charge applied and the	he booking and was bounced due to overbooking. The tariff card / original booking confirm	mation indicating the cost of stay or travel, to be submitted.
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Bail Bond  Bail Bond  ame and contact details of the  ne offense for which the insure  this offense bailable as per the  Please attach the court order stip  Sponsor  ame of the sponsor: I_I_I  ause of accident causing the de	he booking and was bounced due to overbooking. The tariff card / original booking confirm he original bills/receipts for the alternative accommodation/travel that were done also needs detaining authority:  d is in custody:  aws of the country?: Yes No authority: No authority No Please attach more sheets to give details, if necessar Protection	mation indicating the cost of stay or travel, to be submitted.

Name of treating doctor of the sponsor:
Details of medical / surgical treatment given to sponsor:
Dates on which the sponsor was given medical / surgical treatment: From
Please attach medical reports, doctor's statement giving the details of the sponsor and cause of death, and the death certificate of the sponsor. Medical statements from relations/spouse will not be accepted. Please attach more sheets to give details, if necessary.
Compassionate Visit
The person hospitalized: The Insured The Insured's Parent/Spouse/Child
Name of the person hospitalized (if not the insured):
Name, address and telephone number of hospital / clinic where treatment is being given:
Name of treating doctor:
Details of ailment:
Cause of the ailment:
Was the ailment / incident caused due to / aggravated due to a pre-existing condition? Please give details:
Date of onset of ailment: D D M M Y Y Y Y
Nature of treatment:
Date of hospitalisation:  D D M M Y Y Y Y
Treating Doctor's opinion on how many more days the patient will need to be hospitalised:
Treating Doctor's opinion on why the insured cannot be sent back to India for further treatment: (Only applicable if the insured is hospitalised)
Treating Doctor's opinion on the need for an attendant:
Please attach a medical reports and certificate from the doctor confirming the above. Please attach more sheets to give details, if necessary. Please attach Doctors statement specifically stating the need for an attendant.
Study Interruption
Due to hospitalization of the insured
Name, address and telephone number of hospital / clinic where treatment is being given:
Name of treating doctor:
Details of ailment: :
Cause of the ailment: :

Was the ailment / incident caused due to / aggravated due to a pre-existing condition? Please give details:
Date of onset of ailmen t: D D M M Y Y Y Y  Nature of treatment: :
Dates of hospitalisation: From
Tuition fees paid in advance for the year: II_I_I_I
Due to death of sponsor or immediate family member
Name of the sponsor/immediate family member:
Nature of accident causing the demise of the sponsor:
Place of accident of the sponsor: I_I_I_I_I_I_I_I_I_I_I_I_I_I_I_I_I_I_I_
Name of treating doctor:  Details of medical / surgical treatment:  Dates of medical/surgical treatment: From
Tuition fees paid in advance for the year:
Please attach medical reports, statements from the treating doctor and death certificate as proof of the above. Medical statements from relations or spouse will not be accepted. Please also attach the receipts of the university fees paid. Please attach more sheets to give details, if necessary.
I/We hereby agree, affirm and declare that:
a. The statements/information given/stated by me/us in this claim form are true, correct and complete.
b The details of all persons having an interest in the property in respect of which the claim is being made are provided as per the proposal form or by way of an endorsement in the policy. Furthermore, save and except as provided or disclosed in this claim form, no claim made hereunder (or the same/similar claim) has been made or lodged with any other insurance company.
c. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.
d. If I/we have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I/We shall not be entitled to all/any rights to recover thereunder in respect of any or all claims, past, present or future.
e. The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information and documents in respect of the claim.
Place:
Date: Signature of the claimant
*Please read the policy wordings for detailed requirements of documents ICICI Lombard General Insurance Company Ltd. Insurance is the subject matter of the solicitation MISC 29,30,50