ICICI Lombard Travel Insurance

Travel Worry Free

Claim No.: |__|__|__|__|

For office use only

CLAIMS FORM FOR OVERSEAS TRAVEL INSURANCE

Name of insured: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

*Email Id : ____________________

Contact No. In India : *Mobile No. : |__|__|__|__|__|__|__|__|__|__| Landline No. |__|__|__|__|__|__|__|__|__|__|

While Traveling Abroad : ____________________

Policy Start Date : D D M M Y Y Y Y Policy End Date : D D M M Y Y Y Y

**Kindly provide the details to enable us to serve you better

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 D D M M Y Y Y Y To D D M M Y Y Y Y

Is medical evacuation back to the Republic of India needed? Please give detailed reasons of the ailment and reason for transportation :

____

____

Details related to previous/concurrent claim Yes ☐ No ☐ If Yes Cashless/Reimbursement/Both ____________________

☐ Claiming also for daily allowance

Medical treatment cost details:

Sr. No.	Expense details	Amount

The above information given is just a summary report of the incident. Please attach more sheets to give details, if necessary. The claim form should be accompanied with bills / vouchers / reports / discharge summary, and they must mention the name of the person treated, type of ailment, details of individual items of medical treatment provided, and dates of treatment, along with prescriptions and original bills, and they must clearly show the medicines prescribed, price and the receipt stamp of the pharmacy. Treatment taken on different 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 dental surgeon : ____________________

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 : _____

_____

_____

Dates of treatment : From D D M M Y Y Y Y To D D M M Y Y Y Y

Dental treatment cost details:

Sr. No.	Expense details	Amount

The above information given is just a summary report of the incident. Please attach more sheets to give details, if necessary. The claim form should be accompanied with bills / vouchers / reports, and they must mention the name of the person treated, type of ailment, tooth/teeth treated, details of individual items of medical treatment provided, and dates of treatment, along with prescriptions and original bills, and they must clearly show the medicines prescribed, price and the receipt stamp of the pharmacy. Treatment taken on different dates for seperate ailements will be treated as seperate medical claims, where standard deductible will apply for each claim.

☐ Repatriation of Remain

Cause of Death : _____

Dates of death of insured : D D M M Y Y Y Y

Details of expenses incurred for repatriation of remains / funeral :

Sr. No.	Expense details	Amount

Please attach the Official death certificate and a Physician's statement for cause of death. Also, please attach the original bills/receipts of expenses incured.

☐ Checked Baggage Loss

Name of Carrier : _____

Dates Loss : D D M M Y Y Y Y

Place of Loss : _____

Details of items lost :

Sr. No.	Expense details	Amount

Please attach the Property Irregularity Report, proof of ownership of any items valued in excess of US $ 100, & letter from the airline stating the compensation received for lost baggage. Please attach more sheets to give details if necessary.

☐ Checked Baggage Delay

Name of Carrier: _____

Date and Time of Arrival Date : D D M M Y Y Y Y Time H H M M

Port of Disembarkation : _____

Date and Time of Baggage Retrieval: Date D D M M Y Y Y Y Time H H M M

Details of Expenses

Sr. No.	Expense details	Amount

Please attach the original bills of emergency items purchased. Please attach more sheets to give details, if necessary. Date & time of receipt of baggage on the Property Irregularity Report should be specified.

Loss of Passport

Date of Loss : D D M M Y Y Y Y

Place of Loss : _____

Expenses incurred in obtaining new passport:

Sr. No.	Expense details	Amount

Please attach the police report obtained within 24 hours of becoming aware of theft, and bills / vouchers of expenses incurred in obtaining a fresh / duplicate passport. Please attach more sheets to give details, if necessary.

Financial Emergency

Date of Loss : D D M M Y Y Y Y

Reason of Loss : _____

Please attach the original police report filed within 24 hours of becoming aware of robbery. Please attach more sheets to give details, if necessary.

Personal Liability

Name of the aggrieved Third party : _____

Date of Loss : D D M M Y Y Y Y

Place of loss : _____

Reason for loss: (please give details) : _____

_____

Please attach more sheets to give details, if necessary. Please attach proof of judicial decision rendered by a court of law.

Personal Accident

Cause of accident : _____

_____

Nature of injury : _____

_____

Place of accident : _____

Name, address and telephone number of hospital / clinic where treatment was given : _____

_____

_____

_____

Name of treating doctor : _____

Dates of medical / surgical treatment : From D D M M Y Y Y Y To D D M M Y Y Y Y

Loss incurred : (Please Tick ✓)

- ☐ **Death**
- ☐ **Loss or Inability to function of**
- ☐ An arm at the shoulder joint:
- ☐ An arm below the elbow joint:
- ☐ A thumb:
- ☐ Any other finger:
- ☐ A leg up to a joint below the femur:
- ☐ A leg upto the centre of the tibia:
- ☐ A big toe:
- ☐ An eye:
- ☐ An arm to a point above the elbow joint:
- ☐ A head at the wrist:
- ☐ An index finger:
- ☐ A leg above the centre of the femur:
- ☐ A leg up to a point below the knee:
- ☐ A foot at the ankle:
- ☐ Some other toe:
- ☐ Hearing inone ear:

Please attach original bills/vouchers/reports/discharge summary and they must mention, name of the person, cause of accident, details of medical treatment and dates of treatment. Please attach more sheets to give details, if necessary. Please attach post mortem report if applicable.

Hijack Distress Allowance

Name of Carrier : _____

Port of Hijack : _____

Port of Release : _____

Dates of Hijack: From D D M M Y Y Y Y To D D M M Y Y Y Y

Time of Start of Hijack : H H M M

Please attach police report confirming the incident. It should contain the Passport number of the Insured and Period of hijacking. Please attach more sheets to give details, if necessary.

☐ Home Insurance (Fire & Special Perils, Burglary)

Address of the property where loss was sustained : _____

_____

_____

City:_____ State: _____ Pin Code: ☐☐☐☐☐☐

Date & Time of Loss: D D M M Y Y Y Y Time : H H M M

Nature of loss: (Tick where applicable)

☐ Fire ☐ Burglary ☐ Lightning ☐ Explosion/Implosion

☐ Riot, Strike & Malicious Damage ☐ Impact Damage ☐ Aircraft Damage

☐ Subsidence and Landslide, including rockslide ☐ Missile Testing Operation ☐ Leakage from automatic sprinkler system

☐ Bush Fire ☐ Storm, Cyclone, Typhoon, Tempest, Hurricane, Tornado, Flood & Inundation

☐ 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 suspected of the same)

_____

_____

Occupants 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 give reasons):_____

_____

Details of any other insurance cover for the property : _____

_____

_____

Details of Items Lost :

Sr. No.	Prescription of Items Loss	Amount

The above information given is just a brief summary of the incident. Please attach more sheet to give details, if necessary. Please attach first information report, investigation report by the police, fire brigade report, Invoices of owned articles (if required by the company), legal opinion wherever required.

☐ Trip Cancellation & Interruption

☐ Trip Cancelled ☐ Trip Interrupted

Reason for trip cancelled / interrupted: (Tick one)

☐ Illness / Injury ☐ Termination of Employment ☐ Inclement Weather

☐ Loss to home ☐ Abduction / Quarantine ☐ Felonious Assault ☐ Terrorist Incident

Date & Time of Incident: D D M M Y Y Y Y Time H H M M

Person Affected : (Tick one)

☐ Insured ☐ Family Member ☐ Travelling Companion

If not the insured, then please give the following details,

Name of Person: _____

Address of Correspondence: _____

_____

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:

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 Medical reports and doctors statement if trip is cancelled or interrupted due to medical reasons. If due to employment reason, then termination letter from the company shall be submitted. If due to other insured events, police report confirming the incident shall be submitted. In case the cancellation or interruption is owing to the sickness, injury or death of a traveling companion, the original tickets of the insured and the traveling companion indicating travel to the same destination for the same dates needs to be submitted. All the bills / receipts of reasonable additional expenses incurred and/or proof of cancellation charges levied by the carriers shall be submitted.

☐ Trip Delay

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 D M M Y Y Y Y Time H H M M

Person Affected: (Tick one)

☐ Insured ☐ Family Member ☐ Travelling Companion

If not the insured, then please give the following details,

Name of Person: _____

Address of Correspondence: _____

_____

City: _____ State: _____ Pin Code: ☐☐☐☐☐☐

Relationship with Person: _____

Details of the reason for trip delay (how, where and reasons for the same): _____

_____

_____

Details of expenses:

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 Medical reports and doctors' statement, or police report confirming the incident causing the trip delay. In case the delay is owing to the sickness, injury or death of a traveling companion, the original tickets of the insured and the traveling companion indicating travel to the same destination for the same dates needs to be submitted. Please also attach all the bills / receipts of reasonable additional expenses incurred.

☐ Missed Connections

Name of Carrier : _____

Actual Date & Time of Arrival : D D M M Y Y Y Y Time H H M M

Scheduled Date & Time of Arrival : D D M M Y Y Y Y Time H H M M

Date & Time of Departure for Connecting Flight : D D M M Y Y Y Y Time H H M M

Reason for delay: _____

_____

Details of expenses :

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.

☐ Bounced Bookings of Hotel / Airlines

Name of Carrier / Hotel: _____

Booking Date : D D M M Y Y Y Y

Confirmation date : D D M M Y Y Y Y

Reason for bounced booking : _____

_____

Details of additional expenses:

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 letter from the airline or hotel stating that confirmation was done of the booking and was bounced due to overbooking. The tariff card / original booking confirmation indicating the cost of stay or travel, the cancellation charge applied and the original bills / receipts for the alternative accommodation / travel that were done also needs to be submitted.

☐ Bail Bond

Name and contact details of the detaining authority : _____

_____

_____

The offense for which the insured is in custody : _____

_____

_____

Is this offense bailable as per the laws of the country? : Yes ☐ No ☐

Please attach the court order stipulating the required amount as bail bond. Please attach more sheets to give details, if necessary.

☐ Sponsor Protection

Name of the sponsor : _____

Cause of accident causing the demise of the sponsor : _____

_____

Nature of injury causing the demise of the sponsor : _____

_____

Place of accident of the sponsor : _____

Name, address and telephone number of hospital / clinic where treatment was given to the sponsor : _____

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 D D M M Y Y Y Y To D D M M Y Y Y Y

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 ailment : D D M M Y Y Y Y

Nature of treatment : _____

Dates of hospitalisation: From D D M M Y Y Y Y To D D M M Y Y Y Y

Reason for medical evacuation (if applicable): _____

Reason for not continuing studies abroad : _____

_____

Tuition fees paid in advance for the year: I__I__I__I__I__I

☐ **Due to death of sponsor or immediate family member**

Name of the sponsor / immediate family member : _____

Cause of accident causing the demise of the sponsor / reason for death of immediate family member : _____

_____

Nature of accident causing the demise of the sponsor : _____

_____

Place of accident of the sponsor : _____

Name, address and telephone number of hospital / clinic where treatment was given to the sponsor / the immediate family member:

_____

_____

_____

Name of treating doctor : _____

Details of medical / surgical treatment : _____

Dates of medical / surgical treatment: From D D M M Y Y Y Y To D D M M Y Y Y Y

Reason for not continuing studies abroad: _____

_____

Tuition fees paid in advance for the year : H H M M

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.

For any claim related to / on account of accident or personal liability

Please describe the incident : _____

_____

_____

Date of Injury : D D M M Y Y Y Y

Are you Attorney represented for this Injury ? Yes No If yes, complete below :

Attorney Name : _____ Law Firm Name : _____

Phone : _____ Address : _____

_____

_____

Please check the box below that best describes your injury :

☐ **Vehicular Accident**

Type of Vehicle : _____

☐ Single Vehicle Accident ☐ Multiple Vehicle Accident

Vehicle Insurance Information for patient :

Driver Name : _____

Policyholder Name : _____

Insurance Co. Name : _____

Address : _____

_____

Adjuster's Name : _____

Adjuster's Phone : _____

Claim Number : _____

Did you rent a car ? yes ☐ No ☐

If yes,

Owner (Rental Company) : _____

Location of Rental : _____

Important Please provide a copy Rental Receipt and/or Agreement.

Vehicle Insurance Information for Other Party :

Driver Name : _____

Policy holder Name : _____

Insurance Co. Name : _____

Address : _____

_____

Adjuster's Name : _____

Adjuster's Phone : _____

Claim Number : _____

☐ **Premises Injury**

Homeowner or Business Name :

_____

Address : _____

_____

Phone : _____

Insurance Co. Name : _____

Address : _____

_____

Adjuster's Name : _____

Adjuster's Phone : _____

Claim Number : _____

☐ **Product Injury**

Product Name : _____

Company Name : _____

Insurance Co. Name : _____

Address : _____

_____

Adjuster's Name : _____

Adjuster's Phone : _____

Claim Number : _____

☐ **Other Injury**

Please describe (Attach separate sheet 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.

F. I do hereby authorize International Subrogation Management (ISM) to inquire and obtain any information regarding my accident. Further, ICICI Lombard is hereby authorized to release any and all information, including copies of pertinent documents, which ISM may deem necessary in order to satisfy their inquiry, If during the investigation, ISM has identified a potential recovery source, allowing the Plan Participant's employer to recover paid benefits, ISM is authorized to release any all records they deem necessary in order to pursue the recovery.

Place : _____

Date: _____ Signature of the claimant

All information received as a result of this release will not be disseminated to any other entity without the expressed written authorization of the Plan participant, or the Member, if the Participant is a minor. This authorization is valid for one year from the date of signature.

*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