

Annexure 8

VOYAGER GROUP TRAVEL INSURANCE CLAIM FORM

Guidelines for completion of the Claims form

1. Claims Form consists of two parts - Information Sheet and Coverage
2. Please fill the Information Sheet along with the relevant annexure as per the desired coverage.
3. Please take the print out of only the relevant annexure.

Sr. No.	Coverage
Annexure 1	HOSPITALIZATION EXPENSES FOR INJURY
	OUTPATIENT TREATMENT FOR INJURY
	MEDICAL AID COVER
	DAILY ALLOWANCE IN CASE OF HOSPITALIZATION DUE TO INJURY
	CHILD CARE EXPENSES DUE TO INJURY
	HOSPITALIZATION EXPENSES FOR ILLNESS AND INJURY
	OUTPATIENT TREATMENT FOR ILLNESS AND INJURY
	PRE-EXISTING DISEASE COVER
	MEDICAL AID COVER IN CASE OF ILLNESS AND INJURY
	MATERNITY COVER
	DAILY ALLOWANCE IN CASE OF HOSPITALIZATION
	CHILD CARE EXPENSES DUE TO HOSPITALIZATION
	MEDICAL EVACUATION
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INFORMATION SHEET

INSURED DETAILS

Policy No.:

Policy Start Date: / / Policy End Date: / /

Full Name (First) (Middle) (Last)

Mr./ Ms./ Dr.:

Date of Birth: / / Sex: Male ☐ Female ☐

Current Address:

Address in Country of Residence:

Phone No. Overseas: Phone No. India:

Mobile No: Email ID:

Passport No.: Claims Ref No.:(As provided)

Every claim has to be accompanied with original ticket/ boarding pass or copy of the passport indicating the travel dates.

CLAIMANT INFORMATION (If different than "Insured Information" above)

Full Name:

Date of Birth: / / Sex: Male ☐ Female ☐ Relationship with the Policyholder:

Claimant's Address:

Phone No. (Off): Phone No. (Res):

Email ID:

In what capacity are you making this claim?

Terms and conditions

- The Insured shall ensure that the Insured has received, read and understood the terms and conditions as contained in Part I and II of the Policy. If the Insured has not received Part I and Part II of the Policy, please email at customersupport@icicilombard.com.
- In the event of an Accident or sudden illness or occurrence of any other contingency covered under the Policy, the Insured shall immediately contact the Help Line number and register his/ her claim furnishing the necessary details.
- Failure of immediate intimation to the helpline may result in the Insured's claim being prejudiced and in no case being admitted for more than 75% of the claim. No expenses however beyond a limit of US\$ 1000 shall be incurred by the Insured without prior approval from the Company.
- This condition shall be applicable even in cases where the Insured would like to pursue his claim only on his return to his place of residence in spite of his meeting with the contingency covered herein whilst abroad.
- Please note, Deductible amount as mentioned in Policy Schedule must be borne by you.
- Issuance of the claims form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract.
- No claim under Accident & Medical Section will be admitted without Doctor's Report as per format.
- For all expense related/indemnity claims, original bills & receipts would be required.
- Please answer all questions completely. In case of insufficient space, please attach additional sheets.
- Please attach original of all bills, receipts, credit card slips pertaining to your claim. Every claim has to be accompanied with original ticket/ boarding pass or copy of passport indicating the travel dates.

DECLARATION

I/We hereby agree, affirm and declare that:

- The statements/ information given/ stated by me/ us in this claim form are true, correct and complete.
- 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.
- 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.
- 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.
- 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.
- 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.
- The company can, while assessing the claim, call for the additional documents which the Company deems fit for assessment of the claim.

Date: / / Place: Claimant's/ Insured's Signature

AUTHORIZATION BY INSURED/ ON BEHALF OF THE INSURED

- I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the Insured to release any information requested regarding this claim and the loss reported.
- I understand ICICI Lombard General Insurance Company Ltd, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim, will use this information.
- I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original.
- I agree that this authorization shall be valid for the duration of this claim. I also authorize Assistance Service Provider, on behalf of ICICI Lombard General Insurance Company Limited, to obtain any medical records or information to process this claim.
- I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Claimant or authorized person) Relationship with the Insured

Date: / / Place: Insured's Signature

Annexure 1: HOSPITALIZATION EXPENSES FOR INJURY/ OUTPATIENT TREATMENT FOR INJURY / MEDICAL AID COVER / DAILY ALLOWANCE IN CASE OF HOSPITALIZATION DUE TO INJURY / CHILD CARE EXPENSES DUE TO INJURY / HOSPITALIZATION EXPENSES FOR ILLNESS AND INJURY / OUTPATIENT TREATMENT FOR ILLNESS AND INJURY/PRE -EXISTING DISEASE COVER/ MEDICAL AID COVER IN CASE OF ILLNESS AND INJURY / MATERNITY COVER / DAILY ALLOWANCE IN CASE OF HOSPITALIZATION / CHILD CARE EXPENSES DUE TO HOSPITALIZATION / MEDICAL EVACUATION / DENTAL TREATMENT / MEDICAL COVER WHILE ON A CRUISE/ ADVENTURE SPORTS COVER

- Has the customer opted for Cruise Cover? Yes/ No. If Yes, please specifically mention about cruise related claims.
- Has the customer opted for Adventure Sports Cover? Yes/ No. If Yes, please specifically mention about adventure sports related claims.

OUT PATIENT TREATMENT

Nature of Ailment:

State Diagnosis and nature of treatment taken:

Dates of treatment: From DD / MM / YYYY

Date of onset of symptoms DD / MM / YYYY

For maternity claim,

Gestational age in weeks

Type of delivery: Normal / caesarean section

No of children before this

Name, address & telephone number of consulting physician/ dentist/ hospital where treatment was taken

Have you ever been treated for this illness before: Yes/No. If Yes, provide name, address & telephone number of consulted physician:

Provide name, address & telephone number of your family/ regular doctor in India:

Provide name of any prescription medicine you are presently taking:

HOSPITALISATION

(First)

(Middle)

(Last)

Full Name:

Address

Dates of Treatment: From DD / MM / YYYY To: DD / MM / YYYY

Attending Doctor's Report:

Doctor's Telephone Number:

Date of onset of Symptoms: DD / MM / YYYY

Date Doctor Contacted: DD / MM / YYYY Time: Hrs

Nature of Ailment

State diagnosis and nature of treatment provided

When did patient's symptoms first appear?

Describe any other disease or infirmity affecting present condition:

Was the ailment due to Pregnancy: Yes / No

Was the ailment aggravated due to any pre-existing condition? Yes / No If yes, please give details:

Can the patient be evacuated back to the Place of Residence/Place of Origin? Yes / No If yes, please give details:

Is Medical Evacuation back to the Place of Residence/Place of Origin needed? Yes / No If yes, please give details:

Please give detailed reasons of the ailment and reason for transportation:

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MEDICAL TREATMENT EXPENSES DETAILS

Sr. No.	Details of treatment/ expenses	Date	Expenses in Foreign Currency / Indian Rupee (As applicable)

Documents to be submitted in support of the claim:

1.

Medical/Dental reports and discharge/treatment summary issued by the Hospital/Dental Clinic furnishing the name of the Insured, period of treatment and details of treatment rendered.
2.

Bills and receipts and invoices for:

i.

Charges paid towards Hospital accommodation, nursing facilities and other medical/dental services rendered;

ii.

Fees paid to the Medical/Dental Practitioner, special nursing charges, etc;

iii.

Charges incurred towards any and all test and / or examinations rendered in connection with the treatment;

iv.

Charges incurred towards medicines or drugs purchased from a registered pharmacy other than the Hospital/Clinic duly supported by the prescriptions of the Medical/Dental Practitioner attending to the Insured.
3.

Police First Incidence Report (FIR), in case of any road traffic accident or third-party involvement
4.

Post-mortem report, if applicable
5.

Claim documents to be submitted in support of claims under 'Daily Allowance in case of Hospitalization due to Injury', 'Daily Allowance in case of Hospitalization', 'Child Care Expenses due to Injury' & 'Child Care Expenses due to Hospitalization' shall be - Discharge summary, Claim form and Cancelled cheque (or any such document mentioning account details)
6.

Claim documents to be submitted in support of claims under 'Medical Evacuation' - Medical reports and transportation details issued by the evacuation agency, prescriptions and medical report by the attending Medical Practitioner furnishing the name of the Insured and details of treatment rendered along with the statement confirming the necessity of evacuation along with the proof of expenses towards the same.
7.

And any other document as may be appropriately applicable for the claims preferred under these sections of the Policy.

In respect of all claims payable hereunder, the Company may make settlement either in the form of cashless treatment facility or by reimbursement of the amount of claim to the Insured, at its sole discretion. Cashless treatment facility cannot be demanded by the Insured as a matter of right.

Additional documents to be submitted in support of the claim of adventure sports cover:

1.

Medical Practitioner's certificate as a proof that the insured was medically and physically fit to engage in sports activities cover hereunder issued to the insured before the start of the trip and period of insurance.
2.

Correspondence with the governing body or authority of sports activity in which insured was engaged while he/she got injuries stating the reasons/ circumstances in which insured got injured, if applicable.
3.

Medical reports and discharge summary issued by the Hospital furnishing the name of the Insured, period of treatment, details of treatment rendered.
4.

Bills/receipts for

a.

Charges paid towards Hospital accommodation, nursing facilities and other medical services rendered.

b.

Fees paid to the Medical Practitioner, special nursing charges, etc.

c.

Charges incurred towards any and all test and/or examinations rendered in connection with the treatment.

d.

Charges incurred towards medicines or drugs purchased from outside duly supported by the prescriptions of the Medical Practitioner attending on the Insured.
5.

Any other document that may be required to reasonably ascertain the claim admissibility.

Date:

D

D

/

M

M

/

Y

Y

Y

Y

Place:

Claimant's/ Insured's Signature_____

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Annexure 2: LIFESTYLE/WELLNESS

Please select the covers opted

1. Trauma Counseling -

Yes ☐/No ☐
2. Psychiatric Counseling -

Yes ☐/No ☐
3. Physiotherapy –

Yes ☐/No ☐
4. Routine Vision/Dental –

Yes ☐/No ☐
5. Well baby Expenses –

Yes ☐/No ☐
6. Preventive Health check-up.

Yes ☐/No ☐
7. Pharmacy Expense –

Yes ☐/No ☐
8. New Born Baby Day 1 cover –

Yes ☐/No ☐

Full Name:

(First)

(Middle)

(Last)

Address

Doctor's/Counselor/Therapist/Treating Medical Practitioner Telephone Number: No. of consultations taken:

Dates of Treatment: From / / To: / / Date of onset of Symptoms: / /

Attending Doctor's/Counselor/Therapist/Treating Medical Practitioner Report:

Date Doctor/Counselor/Therapist/Treating Medical Practitioner Contacted: / / Time: hrs

Nature of Ailment

State diagnosis and nature of treatment provided

When did patient's symptoms first appear?

Describe any other disease or infirmity affecting present condition:

Was the ailment due to Pregnancy: Yes ☐/No ☐

Was the ailment aggravated due to any pre-existing condition? Yes ☐/No ☐ If yes, please give details:

Can the patient be evacuated back to the Place of Residence/Place of Origin? Yes ☐/No ☐ If yes, please give details:

EXPENSES DETAILS

Sr. No.	Details of treatment/ expenses	Date	Expenses in Foreign Currency

Documents to be submitted in support of the claim:

1. Completed claims form
2. Documents like payment receipts, bills, invoices and other supporting documents as applicable, needed for reimbursement
3. Account Details / Cancelled Cheque

Date: / / Place: Claimant's/ Insured's Signature

Annexure 3: REPATRIATION OF REMAINS

Cause/ Circumstances of death:

Date of death of Insured: D | D | / M | M | / Y | Y | Y | Y |

Details of expenses incurred for repatriation of Remains/ Funeral:

Sr. No.	Details of expenses	Date	Expenses in Foreign Currency

Documents to be submitted in support of the claim:

1. Photocopy of the death certificate providing the details of the place, date and time, and the circumstances and cause of the death (photocopy of the postmortem certificate wherever required by the Assistance Service Provider / TPA / In-house claim settlement team, for cases where postmortem is conducted), issued by the appropriate authority where the contingency has arisen.
2. Proof for expenses incurred towards disposal of the mortal remains.
3. In case of transportation of the body of the deceased to the City of Residence or Place of Origin of the Insured, the receipt for expenses incurred towards preparation and packing of the mortal remains of the deceased and also for the transportation of the mortal remains of the deceased to the City of Residence or Place of Origin of the Insured.
4. And any other document as may be appropriately applicable for the claims preferred under these sections of the Policy.

Date: D | D | / M | M | / Y | Y | Y | Y Place: | | | | | | | | | |

Claimant's/ Insured's Signature _____

Annexure 4: POLITICAL RISK AND CATASTROPHE EVACUATION

Reason for Evacuation: _____

Please detail out the above reason for Evacuation (how, where, when and reason for the same): _____

Evacuation date: / / Original Travel Dates: From: / / Time hrs

Details of Losses/ Expenses Incurred: _____

Sr. No.	Loss/ Expenses Details	Date
Total: _____		

Documents to be submitted in support of the claim:

1. Official Declaration by embassy of Country of Residence of the Insured
2. Original Invoice of Hotel Accommodation during the period in which Insured is unable to return to the Country of Residence.
3. Original ticket(s)/boarding pass or receipt of expenses incurred to travel back to the Country of Residence or the nearest place of safety.
4. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy.

Date: / / Place: Claimant's/ Insured's Signature _____

No. of bags checked-in:
 No. of bags delayed: No. of bags lost: No. of bags damaged during transit:
 Was it a group check-in? Yes ☐ / No ☐ If Yes, give details: _____

No. of checked-in bags that belonged to Insured: _____

No. of delayed bags of Insured: _____ No. of lost bags of Insured: _____ No. of damaged (during Transit) bags of Insured: _____

Describe when & where the Loss/Delay/Damage took place: _____

State the extent of Delay/Loss/Damage: _____

Name the Common Carrier/Public Carrier:.....

1. Flight/Carrier No.: [][][][][][][][] From [D][D] / [M][M] / [Y][Y][Y][Y] To: [D][D] / [M][M] / [Y][Y][Y][Y]

2. Flight/Carrier No.: [][][][][][][][] From [D][D] / [M][M] / [Y][Y][Y][Y] To: [D][D] / [M][M] / [Y][Y][Y][Y]

3. Port of Delay/Loss:

Actual Date & Time of Arrival of Flight/Carrier at Port: D | D | / M | M | / Y | Y | Y | Y H | H | : M | M |

Actual Date & Time when Bags were delivered: / / :

No. of Hours of bag delay: | | | | |

Had the common carrier been notified at the time of loss/damage? Yes /No.

Is the cover for Electronic Equipment Loss/Sports Equipment Loss opted for? Yes /No.

Was the sports equipment/electronic equipment a part of the lost baggage? Yes / No. If Yes, please give the below details

Sr. No.	Item Purchased/ Items Lost	Date of Purchase	Cost in Foreign Currency (In INR for loss claim)
Total:			
Compensation From Carrier:			
Net Amount:			

1. Property irregularity report issued by the common carrier/ Public Carrier (or confirmation of Baggage loss from an independent agency approved by the insurer).
2. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy.

In case the undelivered Checked-In Baggage is subsequently traced by the Common Carrier/ Public Carrier and offered for delivery to the Insured, the Insured shall take delivery of the Checked-In Baggage and refund the amount paid by the Company hereunder. In case of delivery of part of the Checked-In Baggage, the amount paid by the Company attributable to such Checked-In Baggage shall be refunded by the Insured to the Company.

1. Copies of the letter addressed to the Common Carrier/ Public Carrier, police authorities, with their acknowledgment/FIR;
2. In case the value of items which were part of lost baggage/ hand baggage/ cabin baggage is more than 100 US\$, Invoice/purchase bill of the items covered hereunder in case of indemnity claims.
3. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy.

1. Proof of damage to the baggage during the transit certified by the common carrier/Public Carrier or with a picture of the damaged baggage taken during the same trip
2. Visual evidence should show the bag bearing the airline/common carrier/ Public Carrier tag/whereby the name and destination of the passenger should be visible.
3. Any other document as required by the ASP /TPA / Insurer

1. Property irregularity report stating the scheduled time of delivery and actual time of delivery of the Checked-In Baggage issued by the Common Carrier/ Public Carrier (or confirmation of Baggage delay from an independent agency approved by the Insurer).
2. Copies of correspondence exchanged, if any, with the Common Carrier/ Public Carrier in connection with the delay in delivery of the Checked-In Baggage.
3. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy.

In event the compensation has been paid to the Insured under the cover - Delay of Checked-In Baggage and upon further investigation it is later determined that Checked-In Baggage of the Insured has been lost by the Common Carrier/ Public Carrier, any amount claimed and paid to the Insured under the Cover - Delay of Checked-In Baggage will be deducted from any payment due to the Insured under the Cover - Loss of Checked-In Baggage

Date: DD / MM / YY YY Place: _____ Proposer's Signature

Annexure 6: LOSS OF BAGGAGE AND PERSONAL EFFECTS / LOSS OF ELECTRONIC EQUIPMENT / LOSS OF VALUABLE INCLUDING PERSONAL MONEY / LOSS OF TRAVEL DOCUMENTS / LOSS OF SPORTS EQUIPMENT

Date of Loss: / /

Are the cover(s) of Loss of Electronic Equipment/ Loss of Valuable including Personal Money/ Loss of Travel Documents/ Loss of Sports Equipment opted for? Yes /No

If Yes, did the lost baggage include anything that is covered under these extensions? Please name such articles/ equipment: _____

Reason and circumstances of Loss: _____

I hereby declare that the above reason was the sole reason for the Loss of my baggage & personal effects. I have made all efforts to recover my baggage & personal effects unsuccessfully, and if I do secure my baggage & personal effects at a future date, I shall repay to the Company the total claim amount given to me.

SIGNED (Claimant or authorized person) Relationship with the Insured

SIGNED (Claimant or authorized person)

Relationship with the Insured

Details of Losses/ Expenses Incurred:

Sr. No.	Loss/ Expenses Details	Amount
Total: _____		

Details of compensation received: _____

Documents to be submitted in support of the claim:

1. Copies of the letter addressed to the Common Carrier/ Public Carrier, police authorities, hotel/ guest house/ accommodation provider with their acknowledgment/FIR;

2. In case the value of items which were part of lost baggage/ hand baggage/ cabin baggage is more than 100 US\$, Invoice/purchase bill of the items covered hereunder in case of indemnity claims.

3. Any other document as may be appropriately applicable for the claims preferred under this section of the Policy

Date: / /

Place:

Claimant's/ Insured's Signature _____

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Annexure 7: PERSONAL ACCIDENT/COMA COVER/CHILD BENEFIT COVER/WORKPLACE ASSAULT/CHILD EDUCATION GRANT/ ACCIDENTAL DEATH AND DISABLEMENT (COMMON CARRIER/PUBLIC CARRIER)

Please state circumstances of accident i.e. how, when, where it took place: _____

Nature of Injury: _____ State diagnosis _____

Dates of treatment: From DD / MM / YYYY To: DD / MM / YYYY

Which covers had the customer opted for

- i) Coma Cover – Yes /No If Yes, Duration during which in Coma: From DD / MM / YYYY To DD / MM / YYYY
- ii) Child Benefit Cover – Yes /No If Yes, Date of Birth of Child: DD / MM / YYYY
- iii) Workplace Assault – Yes /No If Yes, Duration of Disability: From DD / MM / YYYY To DD / MM / YYYY
- iv) Child Education Grant – Yes /No If Yes, Date of Birth if Child: DD / MM / YYYY

Attending Doctor's Report

Date doctor contacted: DD / MM / YYYY Time: HH : MM

Nature of Injury/Ailment: _____

State diagnosis and nature of treatment provided: _____

Describe any other disease or infirmity affecting present condition:

Was the accident due to any pre-existing condition: Yes No If yes, please give details: _____

Can the patient be evacuated back to the Republic of India? Yes No

Loss Incurred (Please tick): Death _____

Permanent Total Disability: (Details) _____

Permanent Partial Disability: (Details) _____

Coma: Yes /No. Details _____

Documents to be submitted in support of the claim:

- i. Medical reports giving the details of the Accident, nature of Injury and the extent of disability.
- ii. In case of death of the Insured death certificate issued by the Medical Practitioner who attended on the Insured.
- iii. Postmortem certificate, wherever postmortem is conducted, to be produced if required by the Assistance Service Provider/Us.
- iv. Police report/FIR/Panchnama.
- v. In case of an air crash / ship wreck or other such operator causing deaths on a massve scale, confirmation from the common carrier/ Public Carrier operator regarding the death of insured
- vi. Medical Practitioner's certificate in case of Injury (in case of Permanent Partial Disablement/ Permanent Total Disablement) stating the reasons and the extent of the Injury/Disablement.
- vii. And any other document as may be appropriately applicable for the claims preferred under this section of the policy.
- viii. For claims related to extension 'Coma Cover', a letter from the treating doctor certifying the direct cause and duration, the hospitalization course, prognosis of Coma. In case, the Coma has been induced on account of bodily injuries, a written narration from the treating doctor of the circumstances that led to the comatose state shall be needed.

Date: DD / MM / YYYY Place: _____

Claimant's/ Insured's Signature _____

Annexure 8: PERSONAL LIABILITY/COURT ATTENDANCE COVER

Date of Loss: D | D | / M | M | / Y | Y | Y | Y |

[illegible]

Name of aggrieved Third Party: _____

Amount of Liability: _____

Has the Insured Opted for Court Attendance Cover? Yes ☐ /No ☐ If Yes, please provide the following details

1. No. of days the Insured had to attend court))) days

2. Total No. of days of this Court Attendance that fall in the policy period days

Documents to be submitted in support of the claim

1. Statement of claim furnishing particulars of the event leading to the liability
2. Photocopy of the police report wherever reported
3. Proof of judicial decision rendered by a Court of law or any other such Legal document
4. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy

Date: D | D | / M | M | / Y | Y | Y | Y | Place: | | | | | | | | | |

Claimant's/ Insured's Signature _____

Annexure 9: HIJACK DISTRESS ALLOWANCE

Name of Carrier:	
Port of Hijack:	
Port of Release:	
Dates of Hijack: From:	
Time of Hijack: From:	
Name of Claimant:	
Relationship with Insured:	

Documents to be submitted in support of the claim:

The statement of claim shall be accompanied by a certificate of Hijack from the Common Carrier/ Public Carrier, furnishing details of travel by the Insured, the fact of his /her being held captive and confirmation of death, if death shall occur or we may choose to confirm the facts regarding hijack from a third party source, at our own discretion.

Date: DD / MM / YYYY Place: _____ Claimant's/ Insured's Signature_____

Annexure 10: FINANCIAL EMERGENCY CASH ALLOWANCE (LUMP SUM / PER DAY BASIS)

Please select the type of benefit opted – Lump sum ☐ / Per Day Basis ☐

Date of Loss: / /

Reason and circumstances of Loss: _____

Items lost:

Value of the Items lost:

Original Trip Duration: From / / To / /

Amount of Cash carried by you:

Was a Travel card issued at the time of policy issuance? Yes ☐ / No ☐ If Yes, please give the following details-

1. Card Number

2. Issued in the name of _____

3. Card Issuer Company Name

4. Validity of the card: From / / To / /

I hereby declare that the above reason was the sole reason for the loss of my Travel Funds. I also declare that there are no other sources of funds available to me and the financial assistance required by me are needed on an urgent basis to prosecute the remainder of my trip. I have made all efforts to recover my money unsuccessfully, and if I do secure my money at a future date,

I shall repay to the Company the total claim amount given to me.

SIGNED (Claimant or authorized person)

Relationship with the Insured _____

Documents to be submitted in support of the claim:

1. Copy of report to the police authorities having jurisdiction at the place of loss and nature of loss along with the details of loss
2. Confirmation of amount of foreign currency being carried by the insured such as recent exchange receipt of the currency
3. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy

Date: / / Place:

Claimant's/ Insured's Signature

Annexure 11: TRIP CANCELLATION/ FREQUENT FLYER POINTS / EVENT CANCELLATION COVER/ REIMBURSEMENT OF CANCELLATION CHARGES OF PRE-BOOKED EVENTS

Reason for Trip Cancellation:

Please detail out the above reason for trip cancellation (how, where, when and reason for the same):

Trip Cancellation Date: / /

Original Travel Dates: From: / / Time: :

Person Affected and Relationship with the Insured: (If not the Insured, please also provide address and contact details)

Did the customer opt for 'Frequent Flyer points' extension? Yes/No. If Yes, please give details (How many points were used, which card was used, name on card)

Did the customer opt for 'Event Cancellation' Cover? Yes/No. If Yes, please provide details of the event (Where, purpose of the event, no. of people attending, reason of cancellation of event, dates and duration of event)

Did the customer opt for 'Reimbursement of Cancellation charges of pre-booked events' cover? Yes/No. If Yes, please provide details of the event (Where, purpose of the event, no. of people attending, reason of cancellation of event, dates and duration of event)

Details of Losses/Expenses Incurred:

Sr. No.	Loss/ Expenses Details	Amount
Total:		

Documents to be submitted in support of the claim:

- On occurrence of an Insured event that may give rise to a claim in any of the above mentioned covers and its extensions, in the Country of Residence of the Insured or any other intermediate place forming part of the Trip solely resulting from any of the reasons or conditions mentioned in the cover, other than medical reasons, the Insured must submit a duly completed claims form to be accompanied by:
 - Confirmation of cancellation of the Trip from the Common Carrier/ Public Carrier
 - Ticket issued by the Common Carrier/ Public Carrier indicating the cost of the ticket and receipt for the refund of the fare of the Common Carrier/ Public Carrier towards the cancelled portion of the Trip, the cancellation charges retained by the Common Carrier/ Public Carrier or the Travel Agent;
 - Original bill and a receipt/ letter obtained from the hotel and / or guest house indicating the amount paid for the accommodation, the refund given and the cancellation charges retained for the unused portion of the Trip;
- In case the cancellation or interruption and curtailment of the Trip shall result because of personal contingencies covered hereunder, the duly completed claims form to be accompanied by:
 - Medical evidence as may be required by the Assistance Service Provider in case of the cancellation of the Trip arising out of personal contingencies of the Insured or his / her Immediate Family Member;
 - Receipt for the refund of the fare (even if the refund is NIL) of the Common Carrier/ Public Carrier towards the cancelled portion of the Trip indicating the cancellation charges retained by the Common Carrier/ Public Carrier or the Travel Agent;
 - Original bill and a receipt/ letter obtained from the hotel and / or guest house indicating the amount paid for the accommodation, the refund given and the cancellation charges retained for the unused portion of the Trip
 - Used boarding pass in original for return journey from the place of cancellation to the City of Residence or Place of Origin of the Insured together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip in case of Trip Interruption and Curtailment.
- In case the cancellation charges either for the Trip or part of it or in relation to the accommodation in a hotel / guest house / other residential accommodation is waived to the advantage of the Insured subsequent to any settlement of claim under this cover, the Insured shall forthwith return the sum paid by the Company to the extent of such waiver.
- For the extension 'Event Cancellation Cover', proof of purchase of event ticket, confirmation of cancellation of the event from the organizer of the event citing the reasons for cancellation of the event and the cancellation charges retained by them
- For the extension 'Reimbursement of Cancellation charges of pre-booked events', proof of purchase of event ticket, confirmation of ticket cancellation and the cancellation charges retained by them
- For the extension 'Frequent flyer points', confirmation that the ticket of the cancelled trip was purchased using frequent flyer points.
- All claims resulting from injury, illness, quarantine or death must be supported by medical reports or a death certificate (or both) indicating the necessity to cancel your trip. Other reasons should be supported with relevant proofs specific to the circumstances e.g. court summon for the witness, FIR for the loss of passport.
- All claims must be supported by documentary evidence that you have been unable to obtain a full refund from the travel and/or accommodation provider.
- And any other document as may be appropriately applicable for the claims preferred under this section of the Policy

Date: / / Place:

Claimant's/ Insured's Signature

Annexure 12: TRIP CANCELLATION DUE TO VISA REJECTION

Visa Appointment Date & Time: / / Time: : AM/PM

Visa Appointment Place: / /

Country of Travel:

Duration of Travel: / / To / /

Type of Visa applied to.

Any Past/ Current criminal history? Yes/No, If Yes, please give details

Reason for visa rejection

Trip Cancellation Date: / /

Person Affected and Relationship with the Insured: (If not the Insured):

Details of Losses Incurred:

Sr. No.	Loss Details	Amount
Total:		

Documents to be submitted in support of the claim:

1. On occurrence of an Insured event that may give rise to a claim, in the Country of Residence of the Insured or solely resulting from visa rejection, the Insured must submit a duly completed claims form to be accompanied by:
 - a) Confirmation of cancellation of the Trip from the Common Carrier/ Public Carrier
 - b) Ticket issued by the Common Carrier/ Public Carrier indicating the cost of the ticket and receipt for the refund of the fare of the Common Carrier/ Public Carrier towards the cancelled portion of the Trip, the cancellation charges retained by the Common Carrier/ Public Carrier or the Travel Agent;
 - c) Original bill and a receipt/ letter obtained from the hotel and/ or guest house indicating the amount paid for the accommodation, the refund given and the cancellation charges retained for the unused portion of the Trip;
2. In case the cancellation charges either for the Trip or part of it or in relation to the accommodation in a hotel / guest house / other residential accommodation is waived to the advantage of the Insured subsequent to any settlement of claim under this cover, the Insured shall forthwith return the sum paid by the Company to the extent of such waiver.
3. Confirmation of rejection by Visa Authorities, complete set of documents submitted to the Visa Authorities as well as proof of payment of Visa fee will be needed
4. All claims must be supported by documentary evidence that you have been unable to obtain a full refund from the travel and/or accommodation provider.
5. Any other document that may be appropriately applicable for claims preferred under this section of the policy

Date: D | D | / M | M | / Y | Y | Y | Y Place: | | | | | | | | | | | |

Claimant's/ Insured's Signature

Annexure 13: REFUND OF VISA FEE

Visa Appointment Date & Time: / / Time: : AM/PM

Visa Appointment Place:

[illegible]

Duration of Travel: D | D / M | M / Y | Y Y To D | D / M | M / Y | Y Y Y | Y

Type of Visa applied to:

Any Past/Current criminal history? Yes ☐ /No ☐ , If Yes, please give details: _____

Please detail out the documents submitted along with the Visa Application: _____

Details of Visa Application Fees paid:

Sr. No.	Visa Application Details	Amount
Total:		

Documents to be submitted in support of the claim:

1. Proof of visa appointment and visa rejection
2. Any other document that may be appropriately applicable for claims preferred under this section of the policy

Date: D | D / M | M / Y | Y Y | Y Y Place: | | | | | | | | | | Claimant's/ Insured's Signature

Annexure 14: TRIP INTERRUPTION OR CURTAILMENT/TRIP RESUMPTION/REIMBURSEMENT OF CANCELLATION CHARGES OF PRE-BOOKED EVENTS

Reason for Trip Interruption or curtailment:

Please detail out the above reason for trip interruption or curtailment (how, where, when and reason for the same):

Trip Interruption or curtailment Date: / / Original Travel Dates: From: / / Time: : Hrs To: / / Time: : HrsTrip Interrupted on: / / Time: : Hrs

Person Affected and Relationship with the Insured: (If not the Insured, please also provide address and contact details)

Did the customer opt for 'Trip Resumption' extension? Yes/No. If Yes, please give details (where was the trip resumed, details of the travel taken to resume the trip)

Did the customer opt for 'Reimbursement of Cancellation charges of pre-booked events' cover? Yes/No. If Yes, please provide details of the event (Where, purpose of the event, no. of people attending, reason of cancellation of event, dates and duration of event)

Details of Losses/ Expenses Incurred:

Sr. No.	Loss/ Expenses Details	Amount
Total:		

Documents to be submitted in support of the claim:

- On occurrence of an Insured event that may give rise to a claim in any of the above mentioned covers and its extensions, in the Country of Residence of the Insured or any other intermediate place forming part of the Trip solely resulting from any of the reasons or conditions mentioned in the cover, other than medical reasons, the Insured must submit a duly completed claims form to be accompanied by:
 - Confirmation of cancellation of the Trip from the Common Carrier/ Public Carrier
 - Ticket issued by the Common Carrier/ Public Carrier indicating the cost of the ticket and receipt for the refund of the fare of the Common Carrier/ Public Carrier towards the cancelled portion of the Trip, the cancellation charges retained by the Common Carrier/ Public Carrier or the Travel Agent;
 - Original bill and a receipt/ letter obtained from the hotel and / or guest house indicating the amount paid for the accommodation, the refund given and the cancellation charges retained for the unused portion of the Trip;
 - Used air ticket in original for return journey from the place of cancellation to the City of Residence or Place of Origin of the Insured which indicate the cost of the tickets together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip
- In case the cancellation or interruption and curtailment of the Trip shall result because of personal contingencies covered hereunder, the duly completed claims form to be accompanied by:
 - Medical evidence as may be required by the Assistance Service Provider in case of the cancellation of the Trip arising out of personal contingencies of the Insured or his / her Immediate Family Member;
 - Receipt for the refund of the fare (even if the refund is NIL) of the Common Carrier/ Public Carrier towards the cancelled portion of the Trip indicating the cancellation charges retained by the Common Carrier/ Public Carrier or the Travel Agent;
 - Original bill and a receipt/ letter obtained from the hotel and / or guest house indicating the amount paid for the accommodation, the refund given and the cancellation charges retained for the unused portion of the Trip
 - Used boarding pass in original for return journey from the place of cancellation to the City of Residence or Place of Origin of the Insured together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip in case of Trip Interruption and Curtailment.
- In case the cancellation charges either for the Trip or part of it or in relation to the accommodation in a hotel / guest house / other residential accommodation is waived to the advantage of the Insured subsequent to any settlement of claim under this cover, the Insured shall forthwith return the sum paid by the Company to the extent of such waiver.
- For the extension 'Reimbursement of Cancellation charges of pre-booked events', proof of purchase of event ticket, confirmation of ticket cancellation and the cancellation charges retained by them
- For the extension 'Trip Resumption', confirmed common carrier/ Public Carrier ticket and proof of travel
- All claims resulting from injury, illness, quarantine or death must be supported by medical reports or a death certificate (or both) indicating the necessity to cancel your trip. Other reasons should be supported with relevant proofs specific to the circumstances e.g. court summon for the witness, FIR for the loss of passport.
- All claims must be supported by documentary evidence that you have been unable to obtain a full refund from the travel and/or accommodation provider.
- And any other document as may be appropriately applicable for the claims preferred under this section of the Policy

Date: / / Place:

Claimant's/ Insured's Signature

Annexure 15: CANCELLATION COVER FOR HOTEL AND ACCOMMODATION

Reason for cancellation: _____

Please detail out the above reason for cancellation (how, where, when and reason for the same): _____

Trip Cancellation date:

D

D

 /

M

M

 /

Y

Y

Y

Y

Original Travel Dates: From:

D

D

 /

M

M

 /

Y

Y

Y

Y

 To:

D

D

 /

M

M

 /

Y

Y

Y

Y

Person Affected and Relationship with the Insured: (If not the Insured) _____

Details of Losses Incurred:

Sr. No.	Loss Details	Amount
Total: _____		

Documents to be submitted in support of the claim:

1. On occurrence of an Insured event that may give rise to a claim in cover of ‘Cancellation cover for Hotel and Accommodation’, in the Country of Residence of the Insured resulting from any of the reasons or conditions mentioned in the policy wordings, other than medical reasons, the Insured must submit a duly completed claims form to be accompanied by:

a) Original bill and a receipt / letter obtained from the hotel and / or guest house indicating the amount paid for the accommodation, the refund given and the cancellation charges retained for the unused portion of the Trip;

b) We will verify the occurrence of the perils like Hijack, Major Travel Event from an independent third party
2. In case the cancellation of the Trip shall result because of personal contingencies covered under this cover, the duly completed claims form to be accompanied by:

a) Medical evidence as may be required by the Assistance Service Provider/TPA in case of the cancellation of the Trip arising out of personal contingencies of the Insured or his / her Immediate Family Member;

b) Original bill and a receipt / letter obtained from the hotel and / or guest house indicating the amount paid for the accommodation, the refund given and the cancellation charges retained for the unused portion of the Trip
3. In case the cancellation charges either for the Trip or part of it or in relation to the accommodation in a hotel / guest house / other residential accommodation is waived to the advantage of the Insured subsequent to any settlement of claim under this cover, the Insured shall forthwith return the sum paid by the Company to the extent of such waiver.
4. All claims resulting from injury, illness, quarantine or death must be supported by medical reports or a death certificate (or both) indicating the necessity to cancel your trip. Other reasons should be supported with relevant proofs specific to the circumstances e.g. court summon for the witness, FIR for the loss of passport.
5. All claims must be supported by evidence that you have been unable to obtain a full refund from the travel and/or accommodation provider.
6. Any other document that may be appropriately applicable for claims preferred under this section of the policy

Date:

D

D

 /

M

M

 /

Y

Y

Y

Y

 Place: Claimant's/ Insured's Signature _____

Annexure 16: CANCELLATION COVER FOR COMMON CARRIER/PUBLIC CARRIER

Reason for cancellation: _____

Please detail out the above reason for cancellation (how, where, when and reason for the same): _____

Trip Cancellation date: / /

Original Travel Dates: From: / / To: / /

Person Affected and Relationship with the Insured: (If not the Insured) _____

Details of Losses Incurred:

Sr. No.	Loss Details	Amount
Total:		

Documents to be submitted in support of the claim:

1. On occurrence of an Insured event that may give rise to a claim in the Country of Residence of the Insured or any other intermediate place forming part of the Trip solely resulting from any of the reasons or conditions mentioned, other than medical reasons, the Insured must submit a duly completed claims form to be accompanied by:
 - a) Confirmation of cancellation of the Trip from the Common Carrier/ Public Carrier
 - b) Ticket issued by the Common Carrier/ Public Carrier indicating the cost of the ticket and receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the Trip, the cancellation charges retained by the Common Carrier/ Public Carrier or the Travel Agent;
2. In case the cancellation of the Trip shall result because of personal contingencies covered hereunder, the duly completed claims form to be accompanied by:
 - a) Medical evidence as may be required by the Assistance Service Provider/TPA in case of the cancellation of the Trip arising out of personal contingencies of the Insured or his/ her Immediate Family Member;
 - b) Receipt for the refund of the fare of the Common Carrier/ Public Carrier towards the cancelled portion of the Trip indicating the cancellation charges retained by the Common Carrier/ Public Carrier or the Travel Agent;
3. All claims resulting from injury, illness, quarantine or death must be supported by medical reports or a death certificate (or both) indicating the necessity to cancel your trip. Other reasons should be supported with relevant proofs specific to the circumstances e.g. court summon for the witness, FIR for the loss of passport.
4. Any other document that may be appropriately applicable for claims preferred under this section of the policy

Date: D | D | / M | M | / Y | Y | Y | Y Place: | | | | | | | | | |

Claimant's/ Insured's Signature

Annexure 17: OPERATOR DRIVEN COMMON CARRIER/PUBLIC CARRIER CANCELLATIONS

Name of the Travel Aggregator/Operator/Carrier Opted: _____

Please detail out the cancellation (how, where, when and reason given by the Common Carrier/Public Carrier for the same): _____

Trip Cancellation date: / /

Original Travel Dates: From: / / To: / /

Details of Losses Incurred:

Sr. No.	Loss Details	Amount
Total: _____		

- Documents to be submitted in support of the claim:
1. The confirmed ticket / confirmation from the common carrier/ Public Carrier regarding the ticket to insured
 2. The confirmation of cancellation of the common carrier/ Public Carrier should be received, either through the travel aggregator or through the operator himself.
 3. Any other document that may be appropriately applicable for claims preferred under this section of the policy

Date: / / Place: Claimant's/ Insured's Signature_____

Annexure 18: MISMATCH IN CARRIER

Name of the Aggregator/ Carrier Opted:

Type of Carrier booked:

Travel Date by this Carrier: / / To / /

Did you ask the Provider/Aggregator for a change?

Have your received confirmation from Common Carrier regarding the mismatch? Yes / No.

Please detail out the Mismatch experienced (how, where, when and reason given by the Common Carrier/Public Carrier/Aggregator for the same)

- Documents to be submitted in support of the claim:
1. The confirmed ticket / confirmation of the common carrier/ Public Carrier regarding the ticket to insured
 2. The confirmation of any mismatch in type of common carrier/ Public Carrier should be received, either through the channel partner or through the operator himself.
 3. Any other document that may be appropriately applicable for claims preferred under this section of the policy

Date: / / Place: Claimant's/ Insured's Signature

Annexure 19: TRIP CANCELLATION PLUS – COMMON CARRIER/PUBLIC CARRIER

Ticket Booking Date and Time: / / : : Time: : AM/PM

Trip Cancellation date: / /

Original Travel Dates: / / To / /

Details of Losses Incurred:

Sr. No.	Loss Details	Amount
Total:		

Documents to be submitted in support of the claim:

1. Cancellation request from the customer
2. Confirmation from the common carrier/ Public Carrier regarding ticket cancellation
3. Confirmation of the non-refundable amount due after ticket cancellation
4. Any other documents that may be needed

Date: DD / MM / YYYY Place: _____

Claimant's/ Insured's Signature_____

Annexure 20: TRIP CANCELLATION PLUS – HOTELS/OTHER ACCOMMODATIONS

Booking Date and Time:

D

D

/

M

M

/

Y

Y

Y

Y

Time:

H

H

:

M

M

 AM/PM

Trip Cancellation date:

D

D

/

M

M

/

Y

Y

Y

Y

Original Travel Dates:

D

D

/

M

M

/

Y

Y

Y

Y

To

D

D

/

M

M

/

Y

Y

Y

Y

Details of Losses Incurred:

Sr. No.	Loss Details	Amount
Total:		

Documents to be submitted in support of the claim:

1. Cancellation request from the customer
2. Confirmation from hotel regarding cancellation of the reservation
3. Confirmation of the non refundable amount due after cancellation of the reservation
4. Any other documents that may be needed

Date:

D

D

/

M

M

/

Y

Y

Y

Y

Place: Claimant's/ Insured's Signature_____

**Annexure 21: COMMON CARRIER/PUBLIC CARRIER DELAY AND LOUNGE ACCESS/RECREATION COVER FOR COMMON CARRIER/
PUBLIC CARRIER DELAY**

Reason for Delay: _____

Please detail out the reason for trip delay (how, where, when, what was lost and reason for the same:

Original Travel Dates: From: / / To: / /

Trip delayed on: / /

When did the Common Carrier/Public Carrier inform about the delay- Date: / / Time : Hrs

Has the customer opted for Lounge Access/Recreation Cover for Common Carrier/Public Carrier: Yes ☐ /No ☐

Documents to be submitted in support of the claim:

1. Confirmation of delay of the Trip from the Common Carrier/ Public Carrier detailing the circumstances of delay.
The confirmation of this delay can either be procured by the Insured from the Common Carrier/ Public Carrier or We will use the Scheduled / Actual departure time of the Common Carrier/ Public Carrier as recorded by independent external agencies for determining the admissibility of claim.
2. The insured would have to provide documentary evidences to support that he / she reached the scheduled port of departure on time. The evidence could be a stamped boarding pass etc.
3. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy.

Date: DD / MM / YYYY Place: _____ Claimant's/ Insured's Signature_____

Annexure 22: MISSED CONNECTING COMMON CARRIER/PUBLIC CARRIER

Original Travel Schedule (Please give date and time of all Common Carrier/Public Carrier, mentioning the original and actual arrival and departure times. Please also mention the name of carriers and flight/carrier numbers)

Which carrier was delayed causing a Missed Connecting Common Carrier/Public Carrier?

Reason for delay of the carrier:

Details of expenses due to Missed Connecting Common Carrier/Public Carrier:

Sr. No.	Loss Details	Amount
Total:		

Documents to be submitted in support of the claim:

1.

The confirmation of the flight/common carrier/ Public Carrier operator of the delayed flight or Common Carrier/ Public Carrier operator as to the expected time of arrival and the actual time of arrival at the port of delay together with the reasons for delay.
2.

Unused ticket for the Missed Flight or missed Common Carrier/ Public Carrier along with a confirmation of cancellation/ no-show of the same.
3.

Confirmation from the operator of the Missed Flight or Common Carrier/ Public Carrier that the fare for the part of the Trip covered by the Missed Flight/Common Carrier/ Public Carrier is forfeited in full or in part together with the amount of forfeiture, in case of indemnity cover.
4.

Original used ticket, boarding pass obtained afresh towards the alternative flight/Common Carrier/ Public Carrier for the part of the Trip covered by the Missed Flight/Common Carrier/ Public Carrier indicating the amount paid as fare.
5.

And any other document as may be appropriately applicable for the claims preferred under this section of the Policy

Date:

D

D

/

M

M

/

Y

Y

Y

Y

Place: Claimant's/ Insured's Signature

Annexure 23: FIRE AND ALLIED PERILS (HOME BUILDING & CONTENTS)/BURGLARY (HOME CONTENTS)

Address of property where loss was

Sustained: Date of Loss: / /

Cause of Loss: _____

Exact description of nature of loss and it 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 it was discovered:_____

Has the loss been reported to the proper authorities? Yes ☐ No ☐ Please give details of where and to whom the loss has been reported along with the date

and time (If not reported, please give reasons for the same):

Details of any other insurance cover for the property:

Details of Loss Incurred:

Sr. No.	Items lost due to fire/ burglary	Amount
Total:		

Documents to be submitted in support of the claim of Burglary (Home Contents) Cover -

1. The statement of claim furnishing the details of items lost and the values thereof duly supported by purchase bills/Invoices wherever available. In the event of the purchase bills not being available, he / she shall render such evidence as may be required by the surveyor for the latter to arrive at the value of the lost items.
2. First Information Report / Investigation Report by the Police / Panchanama
3. Estimate and final bills of repairers;
4. And any other document as may be appropriately applicable for the claims preferred under this Cover of the Policy.

Documents to be submitted in support of the claim of Fire and allied Perils (Home Building and Contents):

1. First Information Report
2. Panchnama
3. Investigation Report by the Police
4. Fire Brigade Report
5. Estimate and final bills of repairers
6. Invoices of owned articles, if required by the Company
7. Legal opinion wherever required.
8. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy.

Date: | | / | | / | | | | Place: | | | | | | | |

Claimant's/ Insured's Signature _____

Annexure 24: COMPASSIONATE VISIT

Person Hospitalised:

Insured/Family Member

Name of the person hospitalized(If not the insured):

Relationship with Insured:

Provide name, address & telephone number of Hospital/ Clinic:

Treating Doctor's Name & Qualifications:

Treating Doctor's Telephone Number: (O) (M)

Dates of hospitalisation: From: / / Time: Date of onset of symptoms: :

Attending Doctor's Report

Date on which doctor was contacted: / / Time: :

Nature of Ailment:

State diagnosis and nature of treatment provided:

When did patient's symptoms first appear?

Describe any other disease or infirmity affecting present condition:

Was the ailment due to Pregnancy: Yes ☐ No ☐

Was the ailment aggravated due to any pre-existing condition? Yes ☐ No ☐ If yes, please give details:

Can the patient be evacuated back to the Republic of India? Yes ☐ No ☐

Estimated time the patient would continue to be in the hospital?

Expenses Details

Sr. No.	Loss/ Expenses Details	Date	Amount
Total:			

Documents to be submitted in support of the claim:

- Duly completed claims form to be supported by:
1. A certificate from the Medical Practitioner recommending the presence of an Immediate Family Member in the form of special assistance to be rendered during the entire period of Hospitalization. Certificate to also specify the minimum period of Hospitalization.
 2. Discharge summary of the Hospital furnishing details – date of admission, date of discharge, and the presence of the Immediate Family Member on all days of Hospitalization.
 3. Copy of ticket, Copy of passport, visa with exit stamp from India and entry stamp overseas / original boarding pass used for the travel to and fro by the Immediate Family Member. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy.
 4. Copy of invoices and payment receipts for the travel tickets and hotel accommodation, if any.

Date: / /

Place:

Claimant's/ Insured's Signature

Annexure 25: ESCORT OF MINOR CHILDREN

In the Event of Hospitalisation

Person Hospitalised:

Insured/ Family Member Name of the person hospitalized (if not the Insured):

Relationship with the Insured:

Provide name, address & telephone number of Hospital/ Clinic:

Treating Doctor's Name & Qualifications:

Treating Doctor's Telephone Number: (O) (M)

Dates of hospitalisation: From / / Time: / /

Date of onset of symptoms: / /

In Case of Death of the Insured Cause/ Circumstances of death:

Date of death of Insured: / /

Attending Doctor's Report

Date doctor contacted: / / Time: :

Nature of Ailment:

State diagnosis and nature of treatment provided:

When did patient's symptoms first appear?

Describe any other disease or infirmity affecting present condition: Was the ailment due to Pregnancy: Yes ☐ No ☐

Was the ailment aggravated due to any pre-existing condition? Yes ☐ No ☐ If yes, please give details:

Can the patient be evacuated back to the Republic of India? Yes ☐ No ☐

Estimated time the patient would continue to be in the hospital? Yes ☐ No ☐

Is Medical Evacuation back to Republic of India needed? Yes ☐ No ☐ Please give detailed reasons of the ailment and reason for transportation:

Expenses Details

Sr. No.	Details of Expenses	Date	Expenses in Foreign Currency/ INR
Total:			

Documents to be submitted in support of the claim:

Duly completed claims form to be supported by:

1. A certificate from the Medical Practitioner specifying the cause and minimum period of Hospitalisation
2. Discharge summary of the Hospital furnishing details - date of admission, date of discharge and the written confirmation by the attending Medical Practitioner of presence of the attendant member of the family or near relative on all days of Hospitalisation
3. Copy of ticket(s) or boarding pass used for the travel by the Minor Child(ren) back to the City of Residence or Place of Origin, if the ticket(s) are bought on behalf of the Insured without any interference of the Company
4. Photocopy of the death certificate (wherever applicable) providing the details of the place, date and time, and the circumstances and cause of the death (photocopy of the post mortem certificate, wherever required by the Assistance Service Provider, for cases where post mortem is conducted), issued by the appropriate authority where the contingency has arisen

And any other document as may be appropriately applicable for the claims preferred under this section of the Policy

Date: / / Place:

Claimant's/ Insured's Signature

Annexure 26: BOUNCED BOOKINGS OF AIRLINES OR HOTEL

Reason for Bounced Booking: _____

Please detail out the reason for the Bounced Booking (how, where, when, and reason for the same):

Original Travel/ Accommodation Dates: / / To / / From: Days on which the booking was / /

Bounced

Details of Loss Incurred:

Sr. No.	Loss/ Expenses Details	Amount
Total:		

Documents to be submitted in support of the claim:

1. A confirmation from the Common Carrier/ Public Carrier of the bounced booking solely at their instance and responsibility
2. A confirmation from the accommodation provider of the bounced booking solely at their instance and responsibility
3. Insured shall lodge his/ her claim on the Common Carrier/ Public Carrier and/ or the accommodation provider as the case may be for the additional charges that he/ she might have incurred for which he/ she has lodged a claim on this Company and in case of any recovery from the concerned agencies, shall return such recovery to the Company to extent of amount paid hereunder
4. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy
5. Bills and payment receipts for transportation and alternative hotel bookings made
6. Receipts of compensation received from common carrier/ Public Carrier

[illegible]

Claimant's/ Insured's Signature _____

Reason for Delay: _____

Please detail out the above reason for Delay (how, where, when and reason for the same): _____

Delay date: / /

Original Travel Dates: From: / / To: / /

Person Affected and Relationship with the Insured: (If not the Insured, please also provide address and contact details) _____

Sr. No.	Loss/ Expenses Details	Date	Amount
Total:			

1. Receipt for the amount paid to the hotel or guest house or any other accommodation provider
2. Details of the cause of delay in case of major travel events
3. Medical certificate furnishing details of date of admission and date of discharge together with the details of the Injury or Illness and the treatment rendered, obtained from the Medical Practitioner in case of delay being caused because of Hospitalization of the Insured or Insured's travelling companion resulting from any Injury or Illness, as the case may be
4. In case of loss of passport and loss of travel documents, a copy of the first information report in relation to the complaint lodged with the police having jurisdiction over the place of loss and a copy of the application lodged with the passport office for a duplicate passport
5. In case of loss of travel documents, a confirmation/No-show Certificate from the Common Carrier/ Public Carrier that the Insured could not undertake the travel as scheduled
6. In case of delay solely attributable to Common Carrier/ Public Carrier and beyond the control of the Insured a confirmation by the Common Carrier/ Public Carrier of the said delay having taken place at their instance together with a copy of the claim made on the Common Carrier/ Public Carrier for expenses incurred as a result of the delay. At our prerogative, we may choose to verify this information from an independent third party.
7. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy

Date: D | D / M | M / Y | Y | Y | Y Place: | | | | | | | | | | | | | | Claimant's/ Insured's Signature

Annexure 28: AUTOMATIC EXTENSION OF PERIOD OF INSURANCE

Reason for Extension of Trip: _____

Please detail out the above reason for Delay (how, where, when and reason for the same): _____

Extension date: DD / MM / YYYY

Original Travel Dates: From: DD / MM / YYYY To DD / MM / YYYY

Person Affected and Relationship with the Insured: (If not the Insured, please also provide address and contact details) _____

Documents to be submitted in support of the claim:

- 1. The confirmation/correspondence from the Common Carrier/ Public Carrier of the delay stating the circumstances which causes the delay to Common Carrier/ Public Carrier and details of the expected time of arrival and the actual time of arrival at the port of City of Residence or Place of Origin of the Insured and/or we may verify this information from an independent Third Party Source;
- 2. Medical Practitioner’s certificate furnishing details of date of admission and date of discharge in case of Injury or illness stating the reasons and the extent of the Injury/ Illness necessitating the hospitalization of the insured and/or;
- 3. Official confirmation in case of political unrest or terrorism or catastrophe
- 4. And any other document as may be appropriately applicable for the claims preferred under any applicable section due to extension of the policy

Date: DD / MM / YYYY Place: _____ Claimant's/ Insured's Signature _____

Annexure 29: LOSS OF PASSPORT/INTERNATIONAL DRIVING LICENSE

Please provide details of the incident leading to loss of Passport/International Driving License _____

Number of Passport/International Driving License _____

Date of loss of Passport: D | D / M | M / Y | Y | Y | Y Place of loss of Passport: | | | | | | | | | | | | | | | | | |

	Expenses incurred in obtaining new passport:
--	--

Documents to be submitted in support of the claim:

In event of passport loss,

1. Police Report in original obtained within 24 hours, copy of the emergency certificate and application for duplicate passport in the Country of Residence;
2. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy In event of International driving license loss,
 1. Police Report in original
 2. Receipt for payment of charges for obtaining a duplicate international driving license

And any other document as may be appropriately applicable for the claims preferred under this section of the Policy

Date: DD / MM / YY YY Place: | | | | | | | | | | Claimant's/ Insured's Signature

Claimant's/ Insured's Signature _____

Annexure 30: GOLFER’S HOLE IN ONE

Name of the Golf Course: / /

Location of the Golf Course: / /

Event Date and Time: / / Time: : AM/PM

Details of Expenses Incurred:

Sr. No.	Expense Details	Amount
Total:		

Documents to be submitted in support of the claim:

- 1. Confirmation from the Golf course/club stating that the Insured has completed Golfer’s Hole in One at their Golf course/club
- 2. Bills /receipts /invoice of the celebratory drinks on the day of accomplishment
- 3. Any other documents that may be needed

Date: / / Place: Claimant's/ Insured's Signature_____

Annexure 31: CAR RENTAL COVER/RENTAL VEHICLE RETURN

Vehicle Booking Duration: DD / MM / YYYY Time HH : MM AM/PM To DD / MM / YYYY Time: HH : MM AM/PM

Vehicle Rental Company Name:

Vehicle Pickup Location: Original Vehicle Drop-off Location:

Location where the Vehicle was Stolen / Damaged / Collided:

Delayed Vehicle Drop-off Date and Time: DD / MM / YYYY Time: HH : MM AM/PM

Final Vehicle Drop-off Location:

Details of Losses Incurred:

Sr. No.	Loss Details	Amount
Total:		

- Documents to be submitted in support of the claim:
1.

Police First Incidence Report (FIR), in case of any road traffic accident or third-party involvement or theft
2.

Rental agreement/declaration proving hire of vehicle from authorized auto rental company
3.

Confirmation from rental company on charges pressed in event of collision
4.

Photographs of the damage to the rental vehicle (and images of the vehicle before the incident if available)
5.

The accident report from the car rental company or agency
6.

Invoices/Receipts/other documents confirming the amount you have paid in respect of damage for which the car rental company or agency holds you responsible
7.

Any other documents that may be needed

Date: DD / MM / YYYY Place:

Claimant's/ Insured's Signature

Annexure 32: 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.

Documents to be submitted in support of the claim:

1. The Court/Legal order stipulating the required amount as bail bond

Date: / / Place: Claimant's/ Insured's Signature

Annexure 33: MISSED SHORE COVER

Reason given by cruise carrier for missed shore: _____

1. Travel Itinerary stating the shores to be covered as provided by the cruise operator
2. Documented confirmation from operator mentioning missed shores vis-à-vis original Travel Itinerary
3. Confirmed cruise ticket along with the confirmation of you boarding the cruise vessel
4. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy

Claimant's/ Insured's Signature _____

Annexure 34:KIDNAP DISTRESS ALLOWANCE

Original Travel Dates:

D

D

 /

M

M

 /

Y

Y

Y

Y

 To

D

D

 /

M

M

 /

Y

Y

Y

Y

Place where Kidnapped, with Country: _____

Duration for which Kidnapped:

H

H

 :

M

M

 Hrs on

D

D

 /

M

M

 /

Y

Y

Y

Y

 To

H

H

 :

M

M

 Hrs on

D

D

 /

M

M

 /

Y

Y

Y

Y

Name of Claimant: _____

Relationship of claimant with Insured: _____

Details of the Incident (how, where, when): _____

Documents to be submitted in support of the claim:

1.

 Proof of kidnap along with police FIR

2.

 Confirmation of duration for which the insured is kidnapped

3.

 Any other documents that may be needed

Date:

D

D

 /

M

M

 /

Y

Y

Y

Y

 Place: Claimant's/ Insured's Signature _____

Annexure 35: REPLACEMENT AND REARRANGEMENT OF STAFF

Original Travel Schedule (Please give date and time of all destinations):

Whether a part of the Trip was a leisure/non-business Trip? **Yes** ☐/ **No** ☐ If **Yes**, give details of that portion.

Actually completed Travel Schedule (Please give date and time of all destinations):

Reason for being unable to join/complete the Trip in detail:

Person Affected and Relationship with the Insured: (If not the Insured)

Details of expenses incurred:

Sr. No.	Expences	Amount
Total:		

Documents to be submitted in support of the claim:

1. Proof of occurrence of such Insured event
2. Letter from HR of the Insured’s Company, confirming that a replacement is needed
3. Proof of cost incurred on tickets
4. Proof of travel of the insured person and the replacement having occurred (such as a used/stamped boarding pass)
5. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy

Date:

D

D

/

M

M

/

Y

Y

Y

Y

Place:

Claimant's/ Insured's Signature

UIN - ICITGBP20057V011920

38

CIN - L67200MH2000PLC129408

20/Mar/2024/0001

Annexure 36: STUDENT SPONSOR PROTECTION

Name of the sponsor:

Cause of demise of the sponsor:

Nature of injury/illness 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: / / / To: / / /

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.

Tuition fees Claimed:

Documents to be submitted in support of the claim:

a. An official death certificate and a statement from a physician (which physician should not be a relative or spouse of the Insured or the Sponsor) stating cause of death, as proof of death of the Sponsor. Simultaneous claims under 'Study Interruption' and 'Student Sponsor Protection' is not permitted.

b. Official Invoice of the institution regarding payment of the said tuition fee.

c. Documentary evidence that establishes the sponsor-sponsee relationship between the deceased person and the Insured

Date: / / / Place:

Claimant's/ Insured's Signature

Annexure 37: STUDY INTERRUPTION

Due to hospitalisation of the insured

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

Name of treating doctor:

Details of ailment:

[illegible]

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: / / To: / /

Reason for medical evacuation (if applicable):

Reason for not continuing studies abroad: _____

Tuition fees paid in advance for the year: _____

Due to death of sponsor or immediate family member

Name of the sponsor/immediate family member: _____

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

Nature of accident/illness 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:

[illegible]

Details of medical/ surgical treatment: _____

Dates of medical/surgical treatment: From: / / To: / /

Reason for not continuing studies abroad: _____

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.

Documents to be submitted in support of the claim:

- Official invoice form the educational institution.
- Proof of occurrence of Insured event, leading to claim.
- Communication seeking written response from the institute towards refund of the fee for the concerned semester

Date: DD / MM / YY YY Place: | | | | | | | | | | | | | | Claimant's/ Insured's Signature

Claimant's/ Insured's Signature _____

Annexure 38: PET CARE COVER

MEDICAL TREATMENT DUE TO INJURY

Type of Pet:

Age of Pet: Veterinary Doctor's Telephone Number:

Dates of Treatment: From: / / To / / Date of Injury: / /

Attending Doctor's Report:

Date Doctor Contacted: / / Time: : Hrs

Nature of Injury:

State diagnosis and nature of treatment provided:

Describe any other disease or infirmity affecting present condition:

Was the ailment aggravated due to any pre-existing condition? Yes / NO If yes, please give details:

MEDICAL TREATMENT EXPENSES DETAILS

Sr. No.	Details of treatment/ expenses	Date	Expenses in Foreign Currency / Indian Rupee (As applicable)

Documents to be submitted in support of the claim:

- i) Medical reports, bill receipts, discharge summary, charges paid for hospital accommodation, fee paid to the medical practitioner, charges incurred on tests, prescribed medicines etc.
- ii) Proof that the pet was travelling along with the Insured on the Insured Trip
- iii) Any other documents that may be needed

Date: / / Place: Claimant's/ Insured's Signature



ICICI Lombard General Insurance Company Limited

Mailing Address: Interface Building No. 16, 601-602, 6th Floor, New Link Road, Malad (West), Mumbai - 400 064.

Registered Office Address: ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.

Visit us at www.icicilombard.com • Mail us at customersupport@icicilombard.com • Toll Free No.: 1800 2666 • Chargable No.: +91 86 55 222 666

Insurance is the subject matter of solicitation. IRDA Reg. No. 115. • CIN: L67200MH2000PLC129408 • Misc 118.

Part - C- EFT (For Direct Fund Transfer/ Electronic Fund Transfer)

ALL CLAIM SETTLEMENTS SHOULD BE MADE THROUGH NEFT (AS PER IRDA CIRCULAR), PLEASE PROVIDE YOUR BANK ACCOUNT DETAILS.

CLAIM DETAILS

Patient's Name:
(in respect of whom claim is made):
Policy Number:
Card No./ UHID No.:
Group/Company Name
(for Group/Corporate policy holders):
Claim Number (if allotted): Mobile/ Contact No.:

As per IRDA Circular No.: IRDA/F&A/CIR/GLD/056/02/2014, Proposer's/ policy holder's bank account details are mandatory to process the claim through EFT.

Please provide ANY ONE of the below documents of proposer/ policy holder-

- ☐ Please provide a self-attested copy of a valid Identity proof of the Proposer/Policy holder (provide any of the mentioned documents in Proof of Identity under Part-D)
☐ Cancelled cheque copy
☐ Bank attested copy of Passbook with IFSC code

BANK DETAILS

Please provide the below details (all fields are compulsory)

- **Proposer/ policy holder name*** (as per bank records):
- **Proposer/ policy holder Bank account no.:**
- Name of the bank:
- Branch name:
- Address of the bank:
- IFSC code no. of the bank: (should be same as per the provided cheque leaflet)

* Proposer/ policy holder is the person who has paid premium for the policy. All the above details and document(s) should be of Proposer/ policy holder only.

BANK DETAILS

Terms and Conditions for Payments through RTGS/ NEFT

- The details provided by the Proposers/ policy holder in the Mandate Form shall be considered as final and ICICI Lombard General Insurance Company Ltd. shall not be responsible for cross verification of any of the details provided therein.
- The RTGS/ NEFT facility shall be effective for the respective Proposer(s)/ policy holder within 15 days of the receipt of the Mandate Form by ICICI Lombard General Insurance Company Ltd. and/ or within such period as may be reasonably required by ICICI Lombard General Insurance Company Ltd. to activate the RTGS/ NEFT facility.
- The Proposer/ policy holder agrees that under the RTGS/ NEFT facility, there may be a risk of non-payment in the Proposer/ policy holder Accounts No. on the day of the credit of payments due to change in the applicable regulations pertaining to RTGS/ NEFT facility or due to any other reasons without any fault/ inaction/ failure on part of ICICI Lombard General Insurance Company or any factor beyond the control of ICICI Lombard General Insurance Company Limited.
- The Proposer/ policy holder agrees to indemnify, without delay or demur, ICICI Lombard General Insurance Company Ltd. and its agents and keep ICICI Lombard General Insurance Company Ltd. and its agent indemnified harmless at all times from and against any and all claims, damages, losses, costs, and expenses (including attorney's fees) which ICICI Lombard General Insurance Company Ltd. may suffer or incur directly or indirectly, arising from or in connection with, amongst other things, either of the aforesaid reasons stated in above clauses.
- ICICI Lombard General Insurance Company Ltd. may sub-contract and employ agents to carry out any of its obligations under the RTGS/ NEFT facility. The Proposer/ policy holder may discontinue or terminate the use of RTGS/ NEFT facility by giving a minimum of 15 days prior written notice to ICICI Lombard General Insurance Company Ltd. The notice of, such termination should be given to ICICI Lombard only at its corporate address and be addressed at ICICI Lombard GIC Ltd., ICICI Lombard House (Old Tata Press Building), 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai - 400025.
- A confirmation of the receipt of termination notice given by the Proposer/ policy holder will be acknowledged through a confirmation letter by ICICI Lombard General Insurance Company Ltd. In no case can the Proposer/ policy holder construe his termination notice as effective unless a confirmation has been provided by ICICI Lombard to the Proposer/ policy holder stating the date of receipt of such communication by the Proposer/ policy holder.
- The Proposer/ policy holder agrees that transaction(s) through RTGS/ NEFT facility may attract inward RTGS/ NEFT charges, which if levied by the Proposer's/ policy holder's bank, shall be borne by the Proposer/ policy holder only.
- ICICI Lombard has the absolute discretion to amend or supplement any Terms and Condition stated herein at any time and will endeavor to give prior notice of ten days for such changes wherever feasible for the Terms and Conditions to be applicable. By using the new services, or at the completion of such period, whichever is earlier, the Proposer/ policy holder shall be deemed to have accepted the changed Terms and Conditions.
- Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company.
- Notices under these Terms and Conditions may be given in writing by delivering them by hand or e-mail or on ICICI Lombard General Insurance Company Ltd. website www.icicilombard.com or by sending them by post to the last address of the Proposer/ policy holder.
- These Terms and Conditions will be governed by the laws of India and any legal action or proceedings arising out of these Terms and Conditions shall be initiated in the courts or tribunals at Mumbai in India.
- I/We further undertake to refund any excess amount whether demanded by ICICI Lombard General Insurance Company Ltd. or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from ICICI Lombard of such excess credit or such information of excess credit coming to the knowledge of the Proposer/ policy holder through any other source.
- I/We agree that my/ our claim payment will be credited from the date ICICI Lombard General Insurance Company Ltd. gets confirmation from its bankers, This facility will continue unless it is revoked by any party and any issuance of relevant credit instruction from ICICI Lombard General Insurance Company Ltd. to its bankers will be valid till such instruction is complete irrespective of the fact that the notice period has expired provided such a credit request has been made by ICICI Lombard General Insurance Company Ltd. before the expiry of the notice period of the Proposer/ policy holder.

Date: / / Place:

Account holder's Signature



ICICI Lombard General Insurance Company Limited

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Part - C- EFT (For Direct Fund Transfer/ Electronic Fund Transfer)

Part - D (Know Your Customer) KYC

CLAIM DETAILS

KYC details are required for Individual/ Retail policy holders for All claims.

Patient's Name:

(in respect of whom claim is made)

Policy Number: Card No./ UHID No.:

Group/Company Name (for Group/Corporate policy holders)

Claim Number (if allotted): Mobile/ Contact No.:

The below KYC documents are mandatory as per AML guidelines by IRDA

1. ☐ Two passport size photos of Proposer (stick in the space provided below)
2. ☐ One photocopy of proof of identity of Proposer (any 1 in the below list)
3. ☐ One photocopy of proof of residence of Proposer (any 1 in the below list)

Proof of Identity (Any one of below mentioned documents required)	Proof of Residence (Any one of below mentioned documents required)
☐ Passport	☐ Electricity bill
☐ PAN card	☐ Ration card
☐ Voter's Identity card	☐ Letter from any recognized public authority
☐ Driving license	☐ Current statement of bank account with details of permanent/ present residence address (as downloaded)
☐ Personal identification and certification of the employees of the insurer for identity of the prospective policyholder.	☐ Current passbook with details of permanent/present residence address (updated upto the previous month)
☐ Job card issued by NREGA duly signed by an officer of the State Government	☐ Valid lease agreement along with rent receipt, which is not more than three months old as a residence proof.
☐ Letter from a recognized Public Authority (as defined under Section 2 (h) of the Right to Information Act, 2005) or Public Servant (as defined in Section 2(c) of the 'The Prevention of Corruption Act, 1988') verifying the identity and residence of the customer	☐ Telephone bill pertaining to any kind of telephone connection like, mobile, landline, wireless, etc. provided it is not older than six months from the date of insurance contract
	☐ Employer's certificate as a proof of residence (Certificates of employers who have in place systematic procedures for recruitment along with maintenance of mandatory records of its employees are generally reliable)

Proofs of (both) Identity and Residence

- ☐ Passport
- ☐ Written confirmation from the banks where the prospect is a customer, regarding identification and proof of residence. Current passbook with details of present/ permanent residence address (updated to the previous month)
- ☐ Current statement of Bank account with details of present/ permanent residence address (as downloaded)

Stick Proposer's Photographs

Stick
Proposer's
Photograph

Stick
Proposer's
Photograph

Claimant's Signature _____