Overseas Travel Insurance

Claim Form

TATA AIG INSURANCE
WITH YOU ALWAYS

IMPORTANT:
Please contact our 24-hour helpline (our Assistance Center) on
For excluding the Americas Policies : Call:+91 – 022 68227600
Email - ea.tataclaims@europ-assistance.in
For the Americas Policies: Please call: +1-833-440-1575 (Tollfree within US and Canada)
Email - tata.aig@europ-assistance.in

Failure to call our Assistance Company on 24-hour helpline, in respect of Medical Accident & Sickness Claims shall invalidate your claim, if any.

1. This is a One Call Claim Form, except for Accidental Death & Dismemberment (ADD). For ADD, we shall provide a separate Claim Form upon notification.
2. Issuance of the form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract.
3. No claim under Accident & Sickness Section will be admitted without Doctor's Report as per format (Attending Doctor's Report - Page 3)
4. Please answer all questions completely. In case of insufficient space, please attach an additional sheet.
5. Please attach all Original bills & receipts pertaining to your claim.

Insurance Cert. No./Card No. _____ **Period:** From: D D M M Y Y Y Y to: D D M M Y Y Y Y

DETAILS OF PATIENT/INSURED PERSON

Name of the Insured

Name of the Employee

Employee No.

Name of the Claimant

Phone Nos.

Permanent Address (INDIA)

City

State PIN

Phone (O) (R)

Fax Mobile

Bank Account Details: Account Name:

Account No.: IFSC Code

Name of the Bank & Address

City

State PIN

E-mail

Date of Birth: D D M M Y Y Y Y Marital status: Married ☐ Single ☐

Assistance Company Ref No.: _____ Passport No.:

Date of Departure: D D M M Y Y Y Y Flight No. _____ From _____ to _____

Date of Arrival: D D M M Y Y Y Y Flight No. _____ From _____ to _____

MEDICAL ACCIDENT & SICKNESS BENEFIT/RMR/SICKNESS DENTAL RELIEF/EMERGENCY MEDICAL EVACUATION

If accident, details of accident i.e. how, when, where it took place: _____

_____

_____

Date: D D M M Y Y Y Y Place: _____

If sickness, state nature and diagnosis, and advise when & where symptoms first occurred: _____

_____

_____

Date: D D M M Y Y Y Y Place: _____

Name & Address of consulting physician:

City

State PIN

Phone (O) (R)

Fax Mobile

Date: D D M M Y Y Y Y Place: _____

Have you ever been treated for this illness before: Yes No

If yes, provide name & address of consulted physician:

City

State PIN

Phone (O) (R)

Fax Mobile

Provide name & address of your family physician:

City

State PIN

Phone (O) (R)

Fax Mobile

Provide name of any prescription medicine you are presently taking: _____

Indicate other health insurance coverages, including name, address, policy number & certificate number of insurer:

AUTHORIZATION

I hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish to the company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records, a photostat copy of this authorization shall be considered as effective and valid as the original.

Date: D D M M Y Y Y Y

Place: _____ Signature of insured : _____

DETAILS OF MEDICAL EXPENSES

Details of treatment	In/Out Patient		Charges (Currency)	Status of Payment
	From	To	Eg : USD / EURO	Paid/Outstanding
			Paid	
			Outstanding	
			TOTAL	

Whether Assistance Co. was contacted: Yes No If Yes, Reference No. _____

If No, give reasons: _____

ATTENDING DOCTOR'S REPORT

Patient Name

Age Marital status: Married Single

Address

City

State PIN

Phone (O) (R)

Fax Mobile

Date of contacted: D D M M Y Y Y Y Time: A.M. P.M.

FOR ACCIDENTAL INJURY/SICKNESS

Nature of Injury/sickness : _____

Details of incidence: _____

Diagnosis and Treatment given: _____

When did patient's symptoms first appear: _____

Describe any other disease or infirmity affecting present condition: _____

Is condition due to Pregnancy: Yes No Is illness due to any pre-existing condition: Yes No

Signature: _____
Attending Doctor's Signature

LOSS/DELAY OF CHECKED BAGGAGE

Describe when & where the loss/delay took place : _____

State the extent of Loss: _____ Name the common carrier: _____

1. Flight No. _____ From _____ to _____ 2. Flight No. _____ From _____ to _____

Has the common carrier been notified at the time of loss? Yes No Airline Reference No. _____

Details of compensation received from carrier: _____

Scheduled date/time of Arrival: D D M M Y Y Y Y hrs.

Actual date/time when bags delivered D D M M Y Y Y Y hrs. No. of Hours delayed : hrs.

Item Purchased/Lost *	Date of Purchase	Place	Cost
		TOTAL	
Less Compensation received from Airline:			
		Net Amount	

* In case of Delay, please provide details of purchases made
* In case of Loss, please provide details of items lost.

LOSS OF PASSPORT

Please provide details of the incident i.e. when, where and how it happened: _____

Details of Police Report (please attach copy): No: _____ Date: D D M M Y Y Y Y Place: _____

Details of Expense Incurred	Date	Place	Amount
		TOTAL	

TRAVEL DELAY/FLIGHT DELAY

Flight No. _____ Date D D M M Y Y Y Y From _____ to _____

Scheduled date/time of Arrival: D D M M Y Y Y Y hrs.

Actual date/time when bags delivered D D M M Y Y Y Y hrs. No. of Hours delayed : hrs.

Whether accomodation & boarding provided by carrier: Yes No

Details of Expense Incurred	Date	Place	Amount
		TOTAL	

TRIP CANCELLATION/TRIP INTERRUPTION/TRIP CURTAILMENT

Flight No. _____ Date D D M M Y Y Y Y From _____ to _____

Scheduled time of Departure: hrs. Cause for Cancellation/Interruption/curtailment : _____

Details of Expense Incurred*	Date	Place	Amount
Amount refunded by Common Carrier and Hotel			
		TOTAL	

*Please note that this coverage applies if Trip is cancelled due to Illness, Injury or death to: You; Your Traveling Companion; Your Immediate Family Member.

PERSONAL LIABILITY

Please provide details of injury/property damaged: _____

Have you received a legal notice, if Yes, please furnish a copy Yes No

BOUNCED BOOKING OF HOTEL AND AIRLINES

Flight No. _____ Date D D M M Y Y Y Y From _____ to _____

Scheduled date of booking: D D M M Y Y Y Y Cause for bounced booking at hotel/airline: _____

Details of Expense Incurred*	Date	Place	Amount
Amount refunded by the airline / hotel			
		TOTAL	

MISSED DEPARTURE/MISSED CONNECTION

Flight No. _____ Date D D M M Y Y Y Y From _____ to _____

Scheduled date/time of Arrival: D D M M Y Y Y Y hrs.

Actual date/time when bags delivered D D M M Y Y Y Y hrs. No. of Hours delayed : hrs.

Whether accomodation & boarding provided by carrier: Yes No

Details of Expense Incurred*	Date	Place	Amount
		TOTAL	

HIJACKING

Flight details No. _____ From _____ to _____

Scheduled date/time of Departure: D D M M Y Y Y Y hrs. Date & time of Hijack D D M M Y Y Y Y hrs.

Scheduled date/time of Arrival: D D M M Y Y Y Y hrs. Date & time of Returned D D M M Y Y Y Y hrs.

Please provide details of incident: _____

I declare that the above answers are true and correct to the best of my knowledge and that I have not withheld any relevant information which might have otherwise affected the acceptance of my application. I understand and agree that the insurance applied for will become effective only upon acceptance by the company and the premium being fully paid.

Date D D M M Y Y Y Y

Place _____ Signature _____

Disclaimer: Insurance is the subject matter of solicitation