HDFC ERGO General Insurance Company Limited

Overseas Travel Insurance Claim Form

(To be filled in by the Insured Policyholder or Insured's Representative duly authorized by Power of Attorney. Issuance of this claim form is not to be taken as an admission of liability. Please attach all bills, receipts, credit card slips pertaining to your claim)

N.B. Please contact our 24-hour helpline on Ph: 91 11 4189 8872, Fax: 91 11 4189 8871.
E-Mail: hdfcergo@internationalsos.com. ***Failure to call our Assistance Provider on 24-hour helpline, in respect of Medical Accident & Sickness Claims may invalidate your claim.***

POLICY/CERTIFICATE NO _____ *Period from:* _____ *to:* _____

DETAILS OF INSURED

Name

_____

Date of Birth _____ **Sex:** ☐ **Male** ☐ **Female**

Current Address

_____

_____

Phone No. (Res) _____ Phone No. (Off) _____

Email Id.

_____

Permanent Address

_____

_____

Phone No. (Res) _____ Phone No. (Off) _____

Does the insured have any other Health/Accident or Travel Insurance? If yes, please give details below:

Name of Insurer _____ Policy Number _____

Amount (Rs) _____

HDFC ERGO General Insurance Company Limited

Date trip commenced

Schedule date of return

Passport No

Trip Destination

Claims Ref No

CLAIMANT INFORMATION
(If different than "Insured Information" above Name and Age of each person included in the claim)

Name

Date of Birth

Relationship with the Policyholder

Claimant's Address

Phone No. (Res)

Phone No. (Off)

In what capacity are you making this claim?

Please indicate whether claim is in respect of (Tick Boxes)

- ☐ **Accidental Death**
- ☐ **Permanent Disability**
- ☐ **Emergency Medical Expenses**
- ☐ **Emergency Dental Treatment**
- ☐ **Hospital Cash**
- ☐ **Baggage Loss**
- ☐ **Baggage Delay**
- ☐ **Trip Cancellation/Interruption**
- ☐ **Personal Liability**
- ☐ **Any Other**

AUTHORIZATION

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 this information will be used by HDFC General Insurance, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. 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 International SOS 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) PLACE DATE

N.B. Please complete appropriate section of Claim Form and read carefully the instructions relating to supporting documents required. When completed please sign declaration above.

Section A: Accidental Injury Claim (Claimant's Statement)

Date of accident Time

Place accident occurred

Please describe in detail the circumstances of accident (attach separate sheet if needed):

Please describe the nature of Insured's Injuries:

Please list the names and addresses of all treating physicians and hospitals:

Name **Street Address**

City **State** **Pin Code**

Phone No. Did police or other authorities investigate the accident?

If yes, please provide name, address and telephone number of all investigating officers and agencies:

Section B: Emergency Medical Expenses/ Emergency Dental Expenses (Insured's Statement)

Name of Sickness or Injury

Date of Sickness/Injury

Place of Sickness/Injury

Circumstances of Sickness/Injury?

Nature of Sickness/Injuries:

If claim was due to hospitalization was SOS Assistance contacted ☐ Yes ☐ No

If 'NO', please advice on separate sheet.

Please list the names and addresses of all treating physicians and hospitals:

Name **Street Address**

City **State** **Pin Code**

Phone No.

Admitted on: **Discharged on**

Section C: Accidental Injury /Medical Expenses Claim (Accident or Sickness) Attending Physician's Statement

Date of accident/sickness: Date of first treatment:

Please describe in detail the nature of the Insured's injuries

Was the Insured hospitalized? ☐ Yes ☐ No

If yes, please list the names and addresses of all hospitals and all admission/discharge dates:

Did the Insured have any injury or illness prior to the accident that contributed to the accident or to the Insured's present condition?

If yes, please describe:

Were any surgical procedures performed? ☐ Yes ☐ No

If yes, please list all procedures, and dates performed:

What are the Insured's current subjective symptoms?

What are the objective findings? (Please include results of current x-rays, lab tests, etc.)?

Dates of total disability: Dates of partial disability:

From: To: From: To:

Date insured able to return to work:

Was the Insured seen by any other physician? Yes No

If yes, please list the names and addresses of all other physicians:

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician:

Address:

Phone No

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 (Attending Physician) PLACE DATE

Section F : Baggage Protection / Baggage Delay Claim Information

Date of loss, damage or delay _____ **Time of day** _____ **a.m.** _____ **p.m.**

Please describe in detail where and how the loss, damage or delay occurred:

_____

_____

Please describe in detail the nature and extent of loss, damage or delay:

_____

_____

Was loss, damage or delay occurred while insured property was on or in the custody of a common carrier (e.g., railroad, airline, cruise ship, bus, taxi, etc.)? ☐ Yes ☐ No

If yes, please complete the following:

Name of carrier: _____ Flight, trip or tour number: _____

Was the carrier notified at the time of the loss or damage? ☐ Yes ☐ No

If yes, please identify where, when and to whom (name and title) notification was given:

_____

_____

Was extra valuation on property declared? _____ If yes, how much? _____

Was baggage checked at the time of loss or damage? ☐ Yes ☐ No

If yes, please enclose claim check:

_____

Has formal claim been filed against the carrier? ☐ Yes ☐ No

If yes, has payment been made to you? ☐ Yes ☐ No If yes, amount received?

Do you have any other insurance that may provide coverage for this accident or loss? ☐ Yes ☐ No

If yes, please identify name, address and policy number of all other insurance including homeowners, travel club, credit cards, etc.:

Has a claim been filed? ☐ Yes ☐ No If yes, what is the current status of that claim?

Was loss reported to police or other authorities? ☐ Yes ☐ No

If yes, please identify where, when and to whom (name and title) loss was reported:

Case #

Valuation of lost and / or damaged property

Sr. No	Description	Date and place of purchase	Original Cost	Replacement Cost or Estimate	Amount Claimed
1					
2					
3					
4					
5					
6					
7					

(attach bills of sale, receipts or estimates*)*

*Are any claims item used in your business, / occupation or profession?_____ If yes, identify the item(s) by * above*

Section H: Flight Delay Claim Information

Name of the Common Carrier:

Flight No.: From To

Schedule time of Departure Actual time of Departure

Date of Cancellation (if applicable):

Reason of Delay /cancellation:

No. of hours delayed:

Did you miss any connecting flight due to the above delay? ☐ Yes ☐ No

If yes, kindly give details:

Name of the common carrier:

Flight No. : From To

Schedule time of Departure:

Did you receive any compensation from the Common Carrier? ☐ Yes ☐ No

If yes, kindly give details:

Do you have any other insurance that may provide coverage for this delay? ☐ Yes ☐ No

If yes, please provided name, address and policy number of all insurance includes travel club, credit card, etc.:

HDFC ERGO General Insurance Company Limited

Has a claim been filled? ☐ Yes ☐ No

If yes, what is the status of that claim?

DETAILS OF THE EXPENDITURE INCURRED

Sr. No	Description of Items	Date	Place	Amount
1				
2				
3				
4				
5				
6				
7				
			Total	

DISCHARGE VOUCHER

Claim Number: Policy Number:

We here by discharge HDFC ERGO General Insurance Company on any future liability on the claim; upon receipt of sum of Rupees _____ _____from HDFC ERGO General Insurance Company Ltd. as full and final settlement.

Please affix Revenue stamp if the Amount Exceeds Rs.500/-

Authorized Signatory with Name Date Company Stamp

*** Please note on receipt of this Discharge Voucher, HDFC ERGO General Insurance Company Ltd. shall dispatch the claim cheque to you***.

If yes, what is the status of that claim?