

TRAVEL HEALTH INSURANCE POLICY CLAIM FORM
 (The issuance of this form does not imply admission of liability)

NAME OF THE CLAIMANT (IN FULL)		POLICY NUMBER	
ADDRESS		PLAN TYPE	
		PERIOD OF INSURANCE	FROM DD/ MM/ YY TO DD/ MM/ YY
OCCUPATION		DATE TRIP COMMENCED	DD/ MM/ YY
RELATIONSHIP OF THE CLAIMANT WITH THE INSURED PERSON		DATE OF SCHEDULED RETURN	DD/ MM/ YY

SECTION TO WHICH CLAIM PERTAINS: (PLEASE TICK WHICHEVER ONE IS APPLICABLE)

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| <input type="checkbox"/> Health Cover:
o Medical Expenses (Incl. Dental Treatment)
o Hospital Daily Allowance
o Transportation
Personal Liability | <input type="checkbox"/> Baggage:
o Total Loss of Checked Baggage
o Delay of Checked Baggage
<input type="checkbox"/> Financial Emergency Assistance
<input type="checkbox"/> Personal Accident |
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ALL CLAIMS HAVE TO BE SUPPORTED WITH ORIGINAL DOCUMENTS OF EXPENSES / COSTS INCURRED, WHEREVER APPLICABLE

HEALTH COVER (Please attach original Doctor's Certificate, Test Reports and Hospital Papers including Discharge Card)

A. Medical Expenses (including dental treatment)

NAME OF DISEASE CONTRACTED		TREATING DOCTOR / CLINIC / HOSPITAL	
		NAME	
WHEN DISEASE FIRST MANIFESTED	DD/ MM/ YY	ADDRESS	
DATE WHEN TREATMENT STARTED	DD/ MM/ YY	CONTACT NUMBER	
DATE WHEN TREATMENT ENDED	DD/ MM/ YY	NATURE OF DISEASE / INJURY (PLEASE DESCRIBE BRIEFLY)	
DATE OF ADMISSION	DD/ MM/ YY		
DATE OF DISCHARGE	DD/ MM/ YY		
HOSPITAL EXPENSES (PLEASE SHOW EACH HEAD SEPARATELY)			
ROOM RENT		ROOM RENT IN WORDS	
CONSULTANCY CHARGES		CONSULTANCY CHARGES IN WORDS	
COST OF TESTS		COST OF TESTS IN WORDS	
OTHER COSTS		OTHER COSTS IN WORDS	
OUTPATIENT EXPENSES		OUTPATIENT EXPENSES IN WORDS	
TOTAL CLAIM AMOUNT		TOTAL CLAIM AMOUNT IN WORDS	

B. Hospital Daily Allowance

TOTAL NUMBER OF DAYS FOR AMOUNT BEING CLAIMED FOR		TOTAL NUMBER OF DAYS FOR AMOUNT BEING CLAIMED FOR IN WORDS	
TOTAL CLAIM AMOUNT		TOTAL CLAIM AMOUNT IN WORDS	

C. Transportation

IF YOU ARE CLAIMING FOR EXTRA COSTS OF TRANSPORTATION HOME(FOR SELF AND / OR ACCOMPANYING PERSON), MORTAL REMAINS OR BURIAL EXPENSES PLEASE SPECIFY THE NAME OF AIRLINES, BURIAL DETAILS, EXPENSES INCURRED AND OTHER INCIDENTAL COSTS WITH BIFURCATION OF EXPENSES IN AN ATTACHED SHEET

TOTAL CLAIM AMOUNT		TOTAL CLAIM AMOUNT IN WORDS	
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PERSONAL LIABILITY (Please attach Judgment of the Court)

DATE	DD/ MM/ YY	TIME		PLACE OF ACCIDENT	
NATURE OF CLAIM BEING MADE				COURT WHERE THE CASE IS BEING PURSUED	
TOTAL AMOUNT OF AWARD INCLUDING CLAIMANT COST				TOTAL AMOUNT OF AWARD INCLUDING CLAIMANT COST IN WORDS	

LOSS OF CHECKED BAGGAGE / DELAY OF CHECKED BAGGAGE (Please attach Police Report, Property Irregularity Report from the Carrier, Claim Lodged on the Carrier, Baggage Receipt, Money Receipts of essential items purchased)

TOTAL LOSS OF CHECKED BAGGAGE		DELAY OF CHECKED BAGGAGE		
PROPERTY IRREGULARITY REPORT BY CARRIER ATTACHED	<input type="checkbox"/> Yes <input type="checkbox"/> No	NAME OF THE AIRLINE		
CLAIM LODGED ON CARRIER	<input type="checkbox"/> Yes <input type="checkbox"/> No	FLIGHT NUMBER		
		FROM		
		TO		
POLICE REPORT LODGED	<input type="checkbox"/> Yes <input type="checkbox"/> No	SCHEDULED DEPARTURE	DATE	DD/ MM/ YY
			TIME	
NUMBER AND DESCRIPTION OF ITEMS LOST		SCHEDULED ARRIVAL	DATE	DD/ MM/ YY
			TIME	
DESCRIPTION OF ITEMS LOST WITH REGARDS TO NO, NATURE AND COST OF EACH SUCH ITEMS.		ACTUAL DEPARTURE	DATE	DD/ MM/ YY
			TIME	
COST OF ITEMS LOST		ACTUAL ARRIVAL	DATE	DD/ MM/ YY
			TIME	
		DESCRIPTION OF ITEMS PURCHASED WITH REGARDS TO NO, NATURE AND COST OF EACH SUCH ITEMS		
TOTAL CLAIM AMOUNT		TOTAL CLAIM AMOUNT		
TOTAL CLAIM AMOUNT IN WORDS		TOTAL CLAIM AMOUNT IN WORDS		

PERSONAL ACCIDENT (Please attach Police Report, Post Mortem Report, Death Certificate, Medical Report)

DATE	DD/ MM/ YY	TIME		PLACE OF ACCIDENT	
TREATING DOCTOR / CLINIC / HOSPITAL				POLICE REPORT LODGED	<input type="checkbox"/> Yes <input type="checkbox"/> No

NAME			
ADDRESS		FULL DESCRIPTION OF ACCIDENT CAUSE	
CONTACT NUMBER			
NATURE OF INJURY SUSTAINED			
TOTAL CLAIM AMOUNT		TOTAL CLAIM AMOUNT IN WORDS	

Declaration

I/We hereby to the best of my/our knowledge and belief, warrant the truth of the above details in every respect. I/We agree that if we have made already or if I/We make in any of my/our further statements in respect of the said incident or any false or fraudulent declarations or suppress or conceal any material fact, the Policy shall be void and all rights of compensation in respect the present or future claim shall be forfeited.

Place:

Date:

Signature of Claimant/Insured