

# HDFC ERGO General Insurance Company Limited



## Student Suraksha - Student Overseas Travel

(To be filled in by the Insured Policyholder or Insured's Representative duly authorised 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)

Please contact our 24x7 helpline in respect to any claims settlement request.

Toll Free - + 800 08250825	Landline - + 91 - 120 - 4507250 (Chargeable)	Email ID - travelclaims@hdfcergo.com
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Failure to call on our 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) \_\_\_\_\_ Email Id. \_\_\_\_\_

Permanent Address \_\_\_\_\_

Phone No. (Off) \_\_\_\_\_ Phone No. (Res) \_\_\_\_\_

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

Name of Insure \_\_\_\_\_ Policy No. \_\_\_\_\_ Amount (Rs.) \_\_\_\_\_

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. (Off) \_\_\_\_\_ Phone No. (Res) \_\_\_\_\_

In what capacity are you making this claim? \_\_\_\_\_

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

- |  |  |   |   |   |  |
|--|--|---|---|---|--|
| <input type="checkbox"/> Accidental Death    | <input type="checkbox"/> Permanent Disablement | <input type="checkbox"/> Emergency Medical Expenses     | <input type="checkbox"/> Emergency Dental Treatment | <input type="checkbox"/> Loss of Passport   | <input type="checkbox"/> Loss of Baggage |
| <input type="checkbox"/> Compassionate Visit | <input type="checkbox"/> Sponsor Protection    | <input type="checkbox"/> Cancer Screening & Mammography | <input type="checkbox"/> Mental & Nervous Disorder  | <input type="checkbox"/> Study Interruption |  |
| <input type="checkbox"/> Personal Liability  | <input type="checkbox"/> Pregnancy             | <input type="checkbox"/> Bail Bond                      | <input type="checkbox"/> Delay of Baggage           | <input type="checkbox"/> Child Care         |  |

### 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 ERGO 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 authorise services provider of HDFC ERGO 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.

I/We hereby understand, declare, consent and authorise the Company that personal health details, medical history and financial information, as provided to the Company may be utilised for processing the claim made under the Policy. I/We hereby also understand, declare and consent that the Company shall have right to retain and disseminate the same to any service provider for providing services related to insurance.

PLACE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

SIGN (Claimant or authorized person)

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 Form (Claimant's Statement)

Date of accident \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_\_ Place of Accident \_\_\_\_\_

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

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 hospitalisation was SOS Assistance contacted ☐ Yes ☐ No If 'NO', please advise on separate sheet.

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

Name	Address	Phone No.	Admitted on	Discharged on

Details of Claimed Expenses	Amount Charged in local currency	Has bill been paid by you?
		Yes/No
		Yes/No
		Yes/No
<b>Total</b>		Yes/No

## 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? \_\_\_\_ 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? \_\_\_\_ 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 From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates of total partial From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

Date Insured able to return to work \_\_\_\_/\_\_\_\_/\_\_\_\_

Was the Insured seen by any other physician? \_\_\_\_ If yes, please list the names and addresses of all other physicians \_\_\_\_\_

### ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

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.

PLACE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

SIGN (Attending Physician)

## Section D - 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

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

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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 loss or damage? ☐ Yes ☐ No

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

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Was extra valuation of the property declared? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

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

If yes, please enclose claim check ☐ Yes ☐ No

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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?

If yes, please identify the name, address and policy number of all other insurance including Homeowners Travel club, credit card etc

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Has the claim been filed? ☐ Yes ☐ No

If yes, what is the current status of that claim?

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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 damage property

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

(attach bills of sale, receipts or estimates)  
Are any claims items used in your business/ occupation or profession? \_\_\_\_\_. If yes, identify the items by \* above

Name of the Common Carrier: \_\_\_\_\_

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.

PLACE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

SIGN (Claimant or authorized person)

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 E – Sponsor Protection

The following details and documents are required along with the claim form:

Name of the sponsor \_\_\_\_\_

Address of the Sponsor \_\_\_\_\_

Submission of an official death certificate \_\_\_\_\_

Statement from a Physician stating cause of death \_\_\_\_\_

Official invoice(s) from the educational institution and voucher(s) of payment of the said Tuition fees, shall be used for calculating any reimbursement paid by the Company

## Section F – Study Interruption

The following details and documents are required along with the claim form:

Details of hospitalization regarding illness/injury suffered by the insured supported by respective copies/originals of documents duly attested by the Hospital.

In case of death of any one immediate family member or the sponsor during the entire policy period, which leads the Insured to discontinue his / her studies for the remaining part of the current school semester for which Tuition has been paid death certificate of the immediate family member or the sponsor is required.

The Company shall reimburse the Insured, the Tuition fees which have already been advanced to the educational institution less possible/actual refunds, up to the amount stated in the Policy Schedule. Hence details of tuition fees paid and refund received from the educational institution if any has to be provided.

## Section G – Bail Bond

The following documents are required along with the claim form:

1. Copy of FIR/Remand application
2. Copy of summons/warrant
3. Receipt of the bail amt if paid by the insured

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PLACE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

SIGN (Claimant or authorized person)

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.

# HDFC ERGO General Insurance Company Limited

## Consent for Mode of Claim Payment



Name of Insured	<input type="text"/>
Policy Number	<input type="text"/>
Claim Number	<input type="text"/>
Beneficiary Name	<input type="text"/>
Mode of Payment	Cheque <input type="checkbox"/> Fund Transfer <input type="checkbox"/>

(Please tick for mode of payment)

(All Fields are Mandatory in case of Fund Transfer)

Insured's Name as per Bank Account	<input type="text"/>		
Bank Account Number	<input type="text"/>		
Branch Name	<input type="text"/>		
IFSC Code	<input type="text"/>	Email address	<input type="text"/>
Attachments	Cancelled Cheque <input type="checkbox"/>	Bank Passbook Copy	<input type="checkbox"/>

In Support of Bank Details  
(Please tick the type of proof submitted)

Declaration: I Mr. / Mrs / Ms. ....  
undersigned, legal beneficiary of the above claim, declare that all details mentioned in this form are true  
and I agree to the mode of payment against the particular claim number mentioned above.

Signature of Beneficiary

Stamp Required in case of Company

Date

D	D	M	M	Y	Y	Y	Y
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