## **HDFC ERGO General Insurance Company Limited**



#### **Overseas Travel Insurance Claim Form**

(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. Contact Details for Travel Claims. International Toll free No - + 800 08250825 (When dialing from abroad) (When dialing from India) Email ID - travelclaims@hdfcergo.com POLICY/CERTIFICATE NO. \_\_\_ Period from: \_\_\_\_/\_\_\_ to \_\_\_/\_\_\_ Trip Destination \_ Passport No Claims Ref No 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: Policy Number: \_\_ Date trip commenced Schedule date of return \_\_\_\_/\_\_/\_\_ CLAIMANT INFORMATION (If different than "Insured Information" above, Name and Age of each person included in the claim) Date of Birth: Name: Claimant's Address Phone No. (Res) Phone No. (Off) \_ Relationship with the Policyholder: In what capacity are you making this claim? Please indicate whether claim is in respect of ( Tick Boxes) ☐ Accidental Death ☐ Permanent Disablement ☐ Emergency Medical Expenses & Medical Transport/Evacuation ☐ Emergency Dental Benefits ☐ Hospital Cash - Accident Only □ Body Repatriation (Related to Death Cover) □ Emergency Travel Expenses for Family Members □ Emergency Travel Expenses for Replacement Colleague □ Emergency Hotel Extension ☐ Emergency Hotel Accommodation ☐ Loss of Baggage & Personal Documents ☐ Loss of Checked in Baggage ☐ Delay of Checked in Baggage ☐ Flight Delay ☐ Hijacking ☐ Trip Cancellation (Cancellation of to & Fro Journey) ☐ Trip Interruption (Cancellation of Return Journey) ☐ Personal Liability ☐ Loss of Cash ☐ Other (Pls specify) AUTHORIZATION l 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. 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) Place of Accident \_ Date 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: Street Address Pin Code Phone Name Citv State

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 - Accidental Injury/	Emergency Medic	al Expenses/Emerge	ency Dental Expenses (	Insured's Statement	)
Name/Nature of Sickness or Injury:		DI (0) I	п :		
Date of Sickness/Injury//		Place of Sickness	/Injury:		
Circumstances of Sickness/Injury?					
	mbursement bo				
Please list the names and addresses of all tro					
Name	A	Address	Phone No.	Admitted on	Discharged on
Details of Claimed Expe	nses	Amount Charged in lo	cal currency (which currency)	Has bill	been paid by you? Yes/No
Total					
Section C – Accidental Injury	/Medical Expense	es Claim /Dental Exp	enses (Attending Phys	ician's Statement)	
Date of accident/sickness//		Date of first treatn	nent/ Y	es/No	
Please describe in detail the nature of the Ins	sured's injuries				
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Was the Insured hospitalized? If ye	s, please list the names an	nd addresses of all hospitals and	d all admission/discharge dates		
Did the Insured have any injury or illness pric	r to the accident that contri	ibuted to the accident or to the I	nsured's present condition? If yes,	please describe	
Were any surgical procedures performed?	If yes, please list all p	procedures, and dates performe	ed		
What are the Insured's current subjective syn	nntoms?				
That are the mound of same and conjugation by	, promot				
What are the objective findings? (please inclu	ude results of current x-rays	s, lab tests, etc.,)?			
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Dates of total disability From//			Dates of total partial Fro	m/To/_	
Date Insured able to return to work/					
Was the Insured seen by any other physician	? If yes, please list	t the names and addresses of a	Il other physicians		
ATTENDING PHYSICIAN INFORMATION					
Name of Attending Physician					
Address					
Phone					
understand that any person who knowingly a	nd with intent to defraud or a	deceive any insurance company	files a claim containing any materia	lly false, incomplete or misleadi	ng information may be subject to prosecution
for insurance fraud	20114401	, ,	ganj matoria	,,	
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PLACE DATE/					SIGN (Attending Physician)

# Section D - Checked Baggage Loss/ Baggage Delay/ Baggage and Personal Document Loss Information Date of loss, damage or delay \_\_\_\_/\_\_ Time of day a.m Total Delay in hours:\_ 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.)? 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 Was extra valuation of the property declared? If yes, how much? If yes, please enclose claim check No If yes, please identify the name, address and policy number of all other insurance including Homeowners Travel club, credit card etc Has the claim been filed? Yes No If yes, what is the current status of that claim? Was loss reported to police or other authorities? 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 2. 3. 4 5. 6 7 (attach bills of sale, receipts or estimates) If yes, identify the items by \* above Are any claims items used in your business/ occupation or profession? \_ Attached Claim Form (Page 1,2 with Section D) duly completed and signed by the Insured. 2) Original Property Irregularity Report (PIR) from airlines. 3) Claim form submitted to airlines, mentioning the details items lost/ damaged, with their respective cost. (Mandatory) Baggage Loss/ Damage Report OR letter from airlines OR any other document from airlines confirming the loss of items. 5) Copies of Boarding Pass, Ticket and Baggage tags. 6) Copy of 1st and last page of passport along with Visa stamp of entry and exit related to journey (to & fro) from India. 7) Details of Compensation received from Airlines If Any. 8) Original Bills/ Receipts for the items lost. 9) Insured's Indian Bank Cancelled cheque copy or Bank Account statement with A/c No, A/c holder name, Branch name and IFSC code. 10) Employee Id card copy( For corporate policies only)

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)

Note of the counts carrier   Pign No		E - Flight Delay/ Flight Cancellatio					
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What he baggage checked at the time of loss or damage?	if yes, please	identity where, when and to whom (name and title)	notification was given				
What he baggage checked at the time of loss or damage?	Was extra val	uation of the property declared?	If yes how much?				
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Do you have any other insurance that may provide coverage for this socidari or loss?   Ves   No   If yes, plase identify the rome, address and policy number of all other insurance including Homeowners Travel club, credit card etc   Has the claim been filled?   Yes   No   If yes, vital is the current shalls of that claim?			If yes, amount received:				
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If yes, what is the current status of that claim?							
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Sign (Claimant or authorized person)  Claims not falling in the above mentioned sections  Type of claim:  Incidence of claim description:  Place of loss							
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# **HDFC ERGO General Insurance Company Limited**



### **Consent for Mode of Claim Payment**

Stamp Required in case of Company

Name of Insured		
Policy Number		
Claim Number		
Beneficiary Name		
Mode of Payment (Please tick for mode of payment	Cheque Fund Transfer t	
	(All Fields are Mandatory in case of Fund Transfer)	
Insured's Name as per Bank Account		
Bank Account Number		
Branch Name		
IFSC Code	Email address	
Attachments In Support of Bank Details (Please tick the type of proof sometimes of the control o	Cancelled Cheque Bank Passbook Copy submitted)  submitted)  ayee name printed on the cheque is required. If name of payee is not printed on the cheque please attach copy of	f the first page of bank passbook
against the particular claim	n number mentioned above.	
Signature of Bene	eficiary	Date: DD MM YYYYY