HDFC ERGO General Insurance Company Limited

Take it easy!

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) Email ID - travelclaims@hdfcergo.com	Landline - + 91 - 120 - 4507250 (Chargeable) (When dialing from India)

POLICY/CERTIFICATE NO. _____ Period from: ____/____/____ to ____/____/____

Passport No _____ Trip Destination _____ 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:

Name of Insurer: _____ 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)

Name: _____ Date of Birth: _____

Claimant's Address _____

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

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 - Accidental Injury/Emergency Medical Expenses/Emergency Dental Expenses (Insured's Statement)

Name/Nature of Sickness or Injury: _____

Date of Sickness/Injury ____/____/____ Place of Sickness/Injury: _____

Circumstances of Sickness/Injury? _____

Type of claim - ☐ cashless ☐ reimbursement ☐ both

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 (which currency)	Has bill been paid by you? Yes/No
Total		

Section C – Accidental Injury /Medical Expenses Claim /Dental Expenses (Attending Physician's Statement)

Date of accident/sickness ____/____/____ Date of first treatment ____/____/____ Yes/No

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 _____

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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 _____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 our 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? _____

Was the 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 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? ☐ 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					

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PLACE_____ DATE ____/____/____

SIGN (Claimant or authorized person)

Section E - Flight Delay/ Flight Cancellation Claim Information

Name of the common carrier _____

Flight No: _____ From ____/ ____/ ____ To ____/ ____/ ____ a.m./ p.m.

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 our 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? _____

Was the 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 the name, address and policy number of all other insurance including HomeownersTravel club, credit card etc

_____

Has the claim been filed? ☐ Yes ☐ No

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

DETAILS OF EXPENDITURE INCURRED

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

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PLACE_____ DATE ____/____/____

SIGN (Claimant or authorized person)

Claims not falling in the above mentioned sections

Type of claim: _____

Incidence of claim description: _____

_____

_____

Place of loss _____ Date of loss ____/____/_____ Claimed amount _____

Claim Number: _____ Policy Number: _____

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)

Insurance is the subject matter of solicitation. Form No. 391.

HDFC ERGO General Insurance Company Limited

Take it easy!

HDFC ERGO GENERAL INSURANCE

Consent for Mode of Claim Payment

Name of Insured

Policy Number

Claim Number

Beneficiary Name

Mode of Payment (Please tick for mode of payment) Cheque ☐ Fund Transfer ☐

(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 submitted)
Cancelled Cheque ☐ Bank Passbook Copy ☐
Original cancelled cheque with payee name printed on the cheque is required. If name of payee is not printed on the cheque please attach copy of the first page of bank passbook

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