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

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)

☐ Accidental Death	☐ Permanent Disablement	☐ Emergency Medical Expenses	☐ Emergency Dental Treatment	☐ Loss of Passport	☐ Loss of Baggage
☐ Compassionate Visit	☐ Sponsor Protection	☐ Cancer Screening & Mammography	☐ Mental & Nervous Disorder	☐ Study Interruption	
☐ Personal Liability	☐ Pregnancy	☐ Bail Bond	☐ Delay of Baggage	☐ 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
Total		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 _____

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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

_____

_____

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 ☐ Yes ☐ No

_____

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

_____

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					

Name of the Common Carrier: _____

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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.

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

Policy Number

Claim Number

Beneficiary Name

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

(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 Cancelled Cheque ☐ Bank Passbook Copy ☐
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