Bajaj Allianz General Insurance Company Limited
Ground Floor, 32/2 Ashoka Plaza, Next to Weikfield Company, Nagar Road,
Pune - 411 014. Phone No. : +91 20 3030 5858, 1800 22 5858, 1800 102 5858

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OVERSEAS TRAVEL INSURANCE CLAIM FORM

1. This form must be signed and dated in all applicable sections.
2. The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the company, nor a waiver of any of the terms and conditions of the insurance contract.
3. No claim under Accident & Sickness Section will be admitted without Doctor's Report as per format (Attending Doctor's Report - Page 4)
4. Please answer all questions completely. In case of insufficient space, please attach an additional sheet.
5. Please attach all Original bills & receipts pertaining to your claim.

Certificate / Policy No. : ______ Period From : ______ to : ______

Whether Claim was notified : Yes ☐ No ☐ If Yes, Reference No. ______

If No, give reasons : ______

DETAILS OF PATIENT / INSURED PERSON

Name of Insured : ______ Phone Nos. (In India) ______

Date of Birth : ______ Gender : M /F ______ Abroad ______

Name of Claimant : ______ Phone Nos. : ______

Date of Birth : ______ Gender : M / F ______

Current Residence Address (Abroad) : ______

Date of arrival in overseas country ______

Email ID : ______

Permanent Address (INDIA) ______

Date of Scheduled return to India ______

Passport No. : ______

Date of Departure : ______ Flight No. : ______ From ______ To ______

Date of Arrival : ______ Flight No. : ______ From ______ To ______

Please indicate whether claim is in respect of : Accident & Sickness ☐ Travel Delay ☐ Baggage Loss ☐ Baggage Delay ☐ Loss of Passport ☐

* Please complete the Section relevant to your claim.

LOSS / DELAY OF CHECKED BAGGAGE

Describe when & where the loss/delay took place : ______

Amount of Loss : ______

Name the common carrier : ______

1. Flight No. : ______ From ______ To ______

2. Flight No. : ______ From ______ To ______

Has the common carrier been notified at the time of loss ? Yes ☐ No ☐ Airline Reference No. : ______

Is PIR report attached ? Yes ☐ No ☐

Details of compensation received from carrier : ______

Scheduled date / time of Arrival : ____ /____ /____ : ____ : ____ hrs. Actual date / time when bags delivered : ____ /____/____:____:____ hrs.

No. of Hours delayed : ______

Item Purchased / Lost *	Date of Purchase	Place	Cost
		Total	
Less Compensation received from Airline :			
		Net Amount :	

In case of Loss, please provide details of items lost.

MEDICAL ACCIDENT & SICKNESS BENEFIT / Dental Treatment for Emergency Pain Relief / PERSONAL ACCIDENT

Please indicate whether claim is in respect of : Accident & Sickness ☐ Dental Treatment ☐

If accident, details, of accident i.e. how, when, where it took place : ______________________

____

____

Date : ______________ Place : ______________

Has the accident been reported to the Police ? ________ If Yes, Case No : ________ Police Station : ______________

If sickness, state nature and diagnosis, and advise when & where symptoms first occurred : ______________

____

Date : ______________ Place : ______________

Name & Address of consulting physician : ______________________

____

Have you ever been treated for this illness before : Yes ☐ No ☐

If yes, provide name, address & contact number of consulted physician : ______________

____

Provide name & address of your Regular Physician in India : ______________________

____

Provide name of any prescription medicine you are presently taking : ______________________

Indicate other health insurance coverages, including name, address, policy number & certificate number of insurer :

____

____

DETAILS OF MEDICAL EXPENSES

Details Of Treatment	Date of Service		Charges with Currency	Status of Payment
	From	To	USD/Euro/specify if other	Paid/Outstanding
		Paid		
		Outstanding		
		TOTAL		

LOSS OF PASSPORT

Please provide details of the incident i.e. when, where and how it happened : ______________________________

____

____

Details of Police Report (please attach copy): No:____________________Date: __________ Place: ______________

Details of Expense incurred	Date	Place	Amount
		Total	

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agent group policy holder, insurance company, association, employer or benefit plan administrator to furnish to the insurance company named above or its representative, any and all information with respect to any injury or sickness suffered by, the medical history of, or consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payment under the Policy Number identified above. I authorize the group policy holder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment - related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I understand that I or my authorized representative may request a copy of this authorization

Date : ____________________ Place : ____________________

Signature of Claimant or Parent, If claimant is a minor : ______________________________

I hereby certify that the above information is true and correct to the best of my knowledge and belief.

Signature : ____________________ Date : ____________________

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ATTENDING PHYSICIANS STATEMENT

Patient's Name : ______________________ Age : ________ Sex : M/F

Address : ______________________

____

____

Date of first consultation : ______________ Time : ______________

For Accidental Injury

Nature of Injury : ______________________

____

X-Ray Taken : Yes ☐ No ☐ Date taken : ______________

Diagnosis and Treatment Given : ______________________

____

____

Are the injuries solely due to the accident or traceable to any previous injuries / disease ______________

Please mention **past history with duration of any diseases, accidents or hospitalizations** with details : ______________

____

Was he under the influence of intoxicants / alcohol or drugs at the time of accident ? ______________

For Sickness

Nature of Illness : ______________________

____

____

History of Presenting complaints : ______________________

____

Diagnosis and Treatment Given : ______________________

____

____

____

When did patient's symptoms first manifest : ______________________

Please mention **past history with duration of any diseases, accidents or hospitalizations** with details : ______________

____

____

History of the following :-

Ailment	Yes / No, If yes Duration	Ailment	Yes / No, If yes Duration
Hypertension		Diabetes	
Cardiac ailments		Asthma	
Arthritis		Cancer	

Is the present condition due to Pregnancy : Yes ☐ No ☐ Is illness due to any pre-existing condition : Yes ☐ No ☐

Is this claimant Totally Disabled from each and every occupation ? ______________
How long would the claimant be totally disabled ?
How long would the claimant be partially disabled ?
Prognosis of the ailment/injury : ______________________

____

Signature : ______________________ Date : ____________ Reg. No. : ____________
Attending Doctor's Signature and Stamp

Doctor's Name : ______________________

Address & Phone No. : ______________________

____