CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED

Registered and Head Office:" Dare House" 2nd Floor, No.2, N.S.C. Bose Road, Chennai 600 001 customercare@cholams.murugappa.com; Toll free help line 1800 200 5544; www.cholainsurance.com



General Insurance

Leisure Travel Insurance - Claim Form

The issuance of this form is not to be taken as an Admission of Liability. Please answer all questions completely. Use additional sheet, if required. Please attach the document required as indicated. Please note that the list of documents mentioned is an indicative list; the Insurer may ask for any other documents to process the claim. Please attach the medical report in the enclosed format for claim under Personal Accident.

| A. Details of The claimant: | Name of Claimant (in full) | Mr Mrs Ms | Dr Prof M/s |
|---|--|--|--|
| | <u> </u> | <u> </u> | |
| Policy Number | | Period of Insurance D | D M M 2 0 0 Y |
| Address | | | |
| | | | |
| City | Pin code | State | |
| Tel. No. | Fax No. | Mobile | 9 No. |
| Occupation | | E-mail | |
| Relationship of claimant with the insured | Date of commencement | | ate of Scheduled Return DDMM200Y |
| Country visited | | Currency of the count | try |
| Section to which Claim pertains | | . F | of Charles Bassace |
| 1 1 | Repatriation of Remains Dental Treatment oss of Passport Loss of Internation | 1 1 | s of Checked Baggage Accident - Overseas |
| 1.1 | Financial Emergency Hospital Daily ca | | |
| · · · · · · · · · · · · · · · · · · · | Trip Curtaliment Trip delay | Personal | Accident Domestic Home Burglary |
| | | e card, Original bills / receipts / with pre | escriptions and diagnostic /investigative reports, Copy |
| 1111 | p and copy of the ticket and boarding pass. | | |
| Name of disease contacted | | | |
| When disease first manifested | DDMM2000Y Date when treatment st | | when treatment ended DDMM2000Y |
| Date of admission | D D M M 2 0 0 Y Date of discharge | DDMM200Y | |
| Name of treating doctor / clinic / hospita | 91 | | |
| Address | | | |
| Contact number | Nature of Disease/Injury (Please d | escribe briefly) | |
| | | | |
| Hospital expenses (Please show each he | ad separately; Please mention in US Dollars) | | |
| Room rent | Consultancy Charges | Cost of treatment | <u>.</u> |
| Other costs | Outpatient expenses | Cost of tests | Total claim amount |
| | | COSt of tests | |
| | · | | n), mortal remains or burial expenses, please provide |
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I/We hereby to the best of my/our knowledge and belief, warrant the truth of the above details in every respect. I/We agree that if we have made already or if I/We make in any of my/our further statements in respect of the said incident or any false or fraudulent declarations or suppress or conceal any material fact, the Policy shall be void and all rights of compensation in respect the present or future claim shall be forfeited.

Place: