TATA-AIG GENERAL INSURANCE COMPANY LIMITED

AHURA CENTER, 4TH FLOOR,
MAHAKALI CAVES ROAD,
ANDHERI (E), MUMBAI - 400 093

DOMESTIC TRAVEL INSURANCE CLAIM FORM

IMPORTANT:

Assistance Co`s 24hr HelpLine — **E-Mail Id of Assistance Company**

Ph : 011-41898858 / Fax : 011 - 41898801 — **Email: travinsure.tata-aig@internationalsos.com**

Tata-Aig Toll Free no. 1800119966 or you may also call local helpline numbers in your respective cities from any other line Mumbai - 6693500

Delhi - 66603500 Bangalore – 66500001 Pune – 66014156 Chennai – 66841050 Hyderabad – 6662982 Ahmedabad - 66610201

Failure to call our Assistance Company on 24-hour helpline, in respect of Accident Medical Benefit Claims shall invalidate your claim, If any

1. This is a One Cal Claim Form, except for Accidental Death & Dismemberment (ADD). For ADD, we shal provide a separate Claim Form upon notification.
2. **Issuance of the form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract.**
3. No claim under Accident Medical Benefit Section wil be admitted without Doctor's Report as per format (Attending Doctor's Report - Page 3)
4. Please answer al questions completely. In case of insufficient space, please attach an additional sheet.
5. Please attach al Original bil s& receipts pertaining to your claim.

Certificate/ Policy No._____ **Period From** _____ **to:** _____ **PNR NO**

DETAILS OF PATIENT/ INSURED PERSON

Name : _____ Phone Nos. _____

Permenant Address :_____

_____

Email Id :_____

Date of Birth: _____/_____/_____ Sex: M / F

Date of Departure: ___/___/___ Flight No. _____ From _____ to _____

Date of Arrival: ___/___/___ Flight No. _____ From _____ to _____

Please indicate whether claim is in respect of: Accident Medical Expenses Travel Delay ☐ Baggage Loss ☐ ☐

Trip Cancellation / Trip Interruption ☐

[1]Please complete the Section relevant to your claim.

LOSS OF CHECKED BAGGAGE

Describe when & where the loss took place: _____

_____

_____

State the extent 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. _____

Details of compensation received from carrier: _____

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

**** There is deductible of 10% per article and 50% for per bag limit.***

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

FLIGHT / COMMON CARRIER DELAY

Flight/ Train No. _____ Date____/____/_____ From _____ to_____

Scheduled time of Departure:_____ Actual time of Departure: _____ **No. of Hours delayed:**_____

Details of Expense incurred towards meals and lodging*	Date	Place	Amount
		TOTAL	

*Please note that, this coverage applies if trip is delayed for more than 6 hrs due to covered hazard

TRIP CANCELLATION / TRIP INTERRUPTION

Flight No. _____ Date____/____/_____ From _____ to_____

Scheduled time of Departure:_____ Cause for Cancellation / Interruption :_____

Details of Expense incurred*	Date	Place	Amount
Amount refunded by Common Carrier and Hotel			
		TOTAL	

*Please note that this coverage applies if Trip is cancelled due to Sickness, Injury or death to: You; Your Traveling Companion; Your Immediate Family Member.

ACCIDENT MEDICAL BENEFIT

Details of accident i.e. how, when, where it took place:_____

Date:_____ Place: _____

Name & Address of consulting physician: _____

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

If yes, provide name & address of consulted physician: _____

Provide name & address of your treating physician: _____

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 ACCIDENTAL MEDICAL EXPENSES

Details of treatment	In/ Out Patient		Charges	Status of Payment
	From	To		Paid/ Outstanding
			Paid	
			Outstanding	
			'TOTAL	

AUTHORIZATION

I hereby declare that I have suffered injuries\loss as described above and al the details given are ABSOLUTELY TRUE AND CORRECT.

I hereby agree to forfeit al my rights to compensation if any of the foregoing facts and / or details are found to be false or incorrect.

I further authorise the hospital, doctor diagnostic laboratory, organisation, establishment or any other body or person dealt with in the course of this claim to give any information or document sought for by the Insurance Company.

Date: Place:

Signature of insured :_____

Attending Doctor's Report

Patient's Name: _____ Age: _____ Sex: M / F

Address: _____

Date contacted: _____ Time: _____

Nature of Injury: _____

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

Diagnosis and Treatment Given: _____

Describe any other disease or infirmity affecting present condition: _____

Signature:_____

Attending Doctor's Signature

NOTE: This form along with documents is to be sent at the above address.