TATA-AIG GENERAL INSURANCE COMPANY LIMITED

A-501, 5th Floor, Building No.4,
Infinity Park,Gen. A.K. Vaidya Marg,
Dindoshi, Malad (East), Mumbai 400 097

OVERSEAS TRAVEL INSURANCE CLAIM FORM

IMPORTANT:

Please contact our 24-hour helpline (our Assistance Center) on

For the Americas Policies: 1-866-866-2620 (Toll Free) / Direct Dial - 713-260-5520
Email: tata.aig@aig.com.

For rest of the world policies excluding the Americas:Ph : + 603 – 8991- 2012 or +603-8991-2014
Email: TGAP.TATAmedical@travelguard.com

Failure to call our Assistance Company on 24-hour helpline, in respect of Medical Accident & Sickness Claims shall invalidate your claim, if any.

1. This is a One Call Claim Form, except for Accidental Death & Dismemberment (ADD). For ADD, we shall 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 & Sickness Section will be admitted without Doctor's Report as per format (Attending Doctor's Report - Page 3)
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.

Insurance Card No. / Payana No._____ **Period From** _____ **to:** _____

DETAILS OF PATIENT/ INSURED PERSON

Name of the Insured :-
Name of the Employee :_____ **Employee No.** _____
Name of the Claimant : _____ Phone Nos. _____
Permenant Address (INDIA):_____
_____

Bank Account Name (in INDIA) :_____ Account NAME.: _____
Bank Account No.: _____ IFSC Code
Name of the Bank & Address : _____
_____
Account NAME.: _____

Email Id :_____
Date of Birth: _____/_____/_____ Sex: M / F _____
Assistance Company Ref No.: _____ Passport No.: _____
Date of Departure: ___/___/___ Flight No. _____ From _____ to _____
Date of Arrival: ___/___/___ Flight No. _____ From _____ to _____

MEDICAL ACCIDENT & SICKNESS BENEFIT

If accident, details of accident i.e. how, when, where it took place:_____
_____
_____
Date:_____ Place: _____
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 of consulted physician: _____
_____
_____
Provide name & address of your family 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:

AUTHORIZATION

I hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish to the company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records, a photostat copy of this authorization shall be considered as effective and valid as the original.

Date: Place:

Signature of insured :_____

DETAILS OF MEDICAL EXPENSES

Details of treatment	In/ Out Patient		Charges (Currency)	Status of Payment
	From	To	Eg : USD / EURO	Paid/ Outstanding
			Paid	
			Outstanding	
			'TOTAL	

Whether Assistance Co. was contacted: Yes No. If Yes, Reference No. _____

If No, give reasons:_____

_____

Attending Doctor's Report

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

Address: _____

_____

_____

Date contacted: _____ Time: _____

For Accidental Injury

Nature of Injury: _____

_____

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

Diagnosis and Treatment Given: _____

_____

_____

_____

Describe any other disease or infirmity affecting present condition: _____

For Sickness

Nature of Illness: _____

_____

_____

Diagnosis and Treatment Given: _____

_____

_____

_____

When did patient's symptoms first appear: _____

Describe any other disease or informity affecting present condition: _____

_____

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

Signature:_____

Attending Doctor's Signature