

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.TATAmmedical@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 infirmity 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