TATA-AIG GENERAL INSURANCE COMPANY LIMITED

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

OVERSEAS TRAVEL INSURANCE CLAIM FORM

IMPORTANT:

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

For the Americas Policies: 1-866-866-2619 (Toll Free) / Direct Dial - 713-260-5519
Email: tata.aig@aig.com.
For rest of the world policies excluding the Americas: Ph : 0091-11-41898860 / Fax : 0091 - 11 - 41898801
Email: delhi.tata-aig@internationalsos.com

Failure to call our Assistance Company on 24-hour helpline, in respect of Medical Accident & Sickness Claims shall invalidate your claim, if any. Please note, the first US$100 of your medical expenses is deductible, and must be borne by you.

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.

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

DETAILS OF PATIENT/ INSURED PERSON

Name : _____ Phone Nos. _____
Permenant Address (INDIA):_____
_____
_____
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 _____
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: _____
_____
_____
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: _____
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 Delay, please provide details of purchases made***
**** In case of Loss, please provide details of items lost.***

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	

TRAVEL DELAY

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

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

Whether accomodation & boarding provided by carrier: Yes ☐No ☐

Details of Expense incurred	Date	Place	Amount
		TOTAL	

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:

_____

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:_____

_____

_____

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 :_____

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