

OVERSEAS TRAVEL INSURANCE CLAIM FORM

1. This form must be signed and dated in all applicable sections.
2. The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the company, nor a waiver of any of the terms and conditions of the insurance contract
3. Please answer all questions completely. In case of insufficient space, please attach an additional sheet.
4. Please attach all Original bills & receipts pertaining to your claim.

Insurance Cert. No./Card No

Is the claim intimated Yes _____ If No kindly confirm reason _____

DETAILS OF PATIENT/INSURED PERSON

	(First name)	(Middle name)	(Last name)
Name of the Insured	<input type="text"/>		
Name of the Employee	<input type="text"/>		
Name of the Claimant	<input type="text"/>		
Phone Nos Overseas	<input type="text"/>		
Permanent Address	<input type="text"/>		
City	<input type="text"/>	State <input type="text"/>	PIN <input type="text"/>
Phone (O)	<input type="text"/>	Phone (R) <input type="text"/>	Mobile <input type="text"/>
Fax	<input type="text"/>	E-mail <input type="text"/>	
Date of Birth	<input type="text"/>	Passport No.	<input type="text"/>
Date of Departure	<input type="text"/>	Flight No.	<input type="text"/>
Date of Arrival	<input type="text"/>	Flight No.	<input type="text"/>

DETAILS OF INSURED'S INDIAN BANK ACCOUNT (Submission of Cancelled Blank Cheque Leaf with Payee Name Printed OR Copy of the First page of the Bank Passbook is Mandatory)

Name of the Account Holder (As per Bank Account)

Account No (As appearing in the cheque book)

Bank Name

Branch Name & Address

Account Type Saving Current Cash Credit

MICR No. IFSC Code:

PAN Cheque / DD Payable Details:

DECLARATION

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize Bajaj Allianz General Insurance Company Limited, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim

Date:

Place:

Signature of the Insured

PLEASE COMPLETE THE SECTION RELEVANT TO YOUR CLAIM

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> MEDICAL EXPENSES | <input type="checkbox"/> DENTAL TREATMENT | <input type="checkbox"/> MEDICAL EVACUATION | <input type="checkbox"/> HIV |
| <input type="checkbox"/> MATERNITY AND BABY COVER | <input type="checkbox"/> MENTAL ILLNESS AND ALCOHOL RELATED DISORDER | <input type="checkbox"/> CANCER SCREENING | <input type="checkbox"/> HOSPITALIZATION DAILY ALLOWANCE |
| <input type="checkbox"/> CANCER SCREENING AND MAMMOGRAPHY | <input type="checkbox"/> MEDICAL REPATRIATION | <input type="checkbox"/> PRE EXISTING ILLNESS | <input type="checkbox"/> PA COVER IN INDIA |

Name & Address of overseas consulting physician

City State PIN

Phone (O) Phone (R) Mobile

Fax E-mail

Have you ever been treated for this illness before in India:

If yes, provide name & address of consulted physician

City State PIN

Phone (O) Phone (R) Mobile

Fax E-mail

Provide name & address of your family physician:

City State PIN

Phone (O) Phone (R) Mobile

Fax E-mail

