

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 Ph : 011-41898858 / Fax : 011 - 41898801		E-Mail Id of Assistance Company 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 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 Medical Benefit 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:	PNR NO
DETAILS OF PATIENT/ INSURED PERSON			
Name : _____		Phone Nos. _____	
Permanent 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 <input type="checkbox"/> Travel Delay <input type="checkbox"/> Baggage Loss <input type="checkbox"/>			
Trip Cancellation / Trip Interruption <input type="checkbox"/>			
*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 <input type="checkbox"/> <input type="checkbox"/> 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	
			TOTAL	

AUTHORIZATION

I hereby declare that I have suffered injuries/loss as described above and all the details given are ABSOLUTELY TRUE AND CORRECT.
 I hereby agree to forfeit all 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.