

Overseas Travel Insurance Claim Form

Guidelines for completion of the Claims form

1. Claims Form consists of two parts - Information Sheet and Coverage
2. Please fill the Information Sheet along with the relevant annexure as per the desired coverage.
3. Please take the print out of only the relevant annexure.

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In the event of a claim, contact our below 24 -hour helpline numbers

In USA	+1 877 352 7706 (Toll Free)
In Canada	+1 877 352 7706 (Toll Free)
In India	1800 2666 (Toll Free & Accessible in India only)
	+91 92236 22666 (Chargeable)
From the rest of the world	+91 22 6787 2010 (Call Back Facility)
Fax	+91 22 6734 7888
E-mail	icicilombard@europ-assistance.in
Claim Processing Department Address	ICICI Lombard General Insurance Company Limited, C/O Europ Assistance India Pvt Ltd. 301, C Wing, Business Squaree, Andheri Kurla Road, Chakala, Andheri (E), Mumbai - 400 093, India

INFORMATION SHEET

INSURED DETAILS

Policy No.: _____
Policy Start Date: / / Policy End Date: / /
(First) (Middle) (Last)
Full Name: _____
Date of Birth: / / Sex: Male Female
Current Address: _____
Address in Country of Residence: _____
Phone No. Overseas: _____ Phone No. India: _____
Mobile No: _____ Email ID: _____
Passport No.: _____ Claims Ref No.:(As provided) _____

Every claim has to be accompanied with original ticket/ boarding pass or copy of the passport indicating the travel dates.

CLAIMANT INFORMATION (If different than "Insured Information" above)

Full Name: _____
Date of Birth: / / Sex: Male Female Relationship with the Policyholder: _____
Claimant's Address: _____
Phone No. (Off): _____ Phone No. (Res): _____
Email ID: _____

In what capacity are you making this claim?

Terms and conditions

1. The Insured shall ensure that the Insured has received, read and understood the terms and conditions as contained in Part II and III of the Policy. If the Insured has not received Part II and Part III of the Policy, please email at customersupport@icicilombard.com.
2. In the event of an Accident or sudden Illness or occurrence of any other contingency covered under the Policy, the Insured shall immediately contact the Help Line number and register his/ her claim furnishing the necessary details.
3. Failure of immediate intimation to the helpline may result in the Insured's claim being prejudiced and in no case being admitted for more than 75% of the claim. No expenses however beyond a limit of US\$ 1000 shall be incurred by the Insured without prior approval from the Company.
4. This condition shall be applicable even in cases where the Insured would like to pursue his claim only on his return to his place of residence in spite of his meeting with the contingency covered herein whilst abroad.
5. Please note, Deductible amount as mentioned in Policy Schedule must be borne by you.
6. Issuance of the claims form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract.
7. No claim under Accident & Medical Section will be admitted without Doctor's Report as per format.
8. Please answer all questions completely. In case of insufficient space, please attach additional sheets.
9. Please attach original of all bills, receipts, credit card slips pertaining to your claim. Every claim has to be accompanied with original ticket/ boarding pass or copy of passport indicating the travel dates.

DECLARATION

I/We hereby agree, affirm and declare that:

1. The statements/ information given/ stated by me/ us in this claim form are true, correct and complete.
2. The details of all persons having an interest in the property in respect of which the claim is being made are provided as per the proposal form or by way of an endorsement in the policy. Furthermore, save and except as provided or disclosed in this claim form, no claim made hereunder (or the same/ similar claim) has been made or lodged with any other insurance company.
3. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.
4. If I/ We have given/ made any false or fraudulent statement/ information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I/ We shall not be entitled to all/ any rights to recover thereunder in respect of any or all claims, past, present or future.
5. The receipt of this claim form/ other supporting/ related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/ additional information and documents in respect of the claim.
6. I do hereby authorize International Subrogation Management (ISM) to inquire and obtain any information regarding my accident. Further, ICICI Lombard is hereby authorized to release any and all information, including copies of pertinent documents, which ISM may deem necessary in order to satisfy their inquiry, If during the investigation, ISM has identified a potential recovery source, allowing the Plan Participant's employer to recover paid benefits, ISM is authorized to release any all records they deem necessary in order to pursue the recovery.
7. The company can, while assessing the claim, call for the additional documents which the Company deems fit for assessment of the claim.

Dated: / / Place: _____

Claimant's/ Insured's Signature

AUTHORIZATION BY INSURED/ ON BEHALF OF THE INSURED

1. I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the Insured to release any information requested regarding this claim and the loss reported.
2. I understand ICICI Lombard General Insurance Company Ltd, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim, will use this information.
3. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original.
4. I agree that this authorization shall be valid for the duration of this claim. I also authorize Assistance Service Provider, on behalf of ICICI Lombard General Insurance Company Limited, to obtain any medical records or information to process this claim.
5. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Claimant or authorized person)

Relationship with the Insured

Dated: / / Place:

Insured's Signature

Annexure 2: REPATRIATION OF REMAINS

Cause/ Circumstances of death: _____

Date of death of Insured: / /

Details of expenses incurred for repatriation of Remains/ Funeral:

Sr. No.	Details of expenses	Date	Expenses in Foreign Currency
		<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
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Total:			

Documents to be submitted in support of the claim:

1. Photocopy of the death certificate providing the details of the place, date and time, and the circumstances and cause of the death (photocopy of the postmortem certificate wherever required by the Assistance Service Provider), issued by the appropriate authority where the contingency has arisen.
2. Proof for expenses incurred towards disposal of the mortal remains.
3. In case of transportation of the body of the deceased to the Country of Residence of the Insured, the receipt for expenses incurred towards preparation and packing of the mortal remains of the deceased and also for the air transportation of the mortal remains of the deceased to the Country of Residence of the Insured.

Dated: / / Place:

Claimant's/ Insured's Signature

Annexure 3: CHECKED-IN BAGGAGE LOSS/ DELAY

Describe when & where the Loss/ Delay took place: _____

State the extent of Delay/ Loss: _____

Name the common carrier: _____

Flight Details:

1. Flight No.: _____ From DD/MM/YYYY To: DD/MM/YYYY

2. Flight No.: _____ From DD/MM/YYYY To: DD/MM/YYYY

Port of Delay/ Loss: _____

Actual Date & Time of Arrival of flight at Port: DD/MM/YYYY HH:MM

Actual Date & Time when Bags were delivered: DD/MM/YYYY HH:MM

No. of Hours of bag delay: _____ Had the common carrier been notified at the time of loss? Yes No

Details of compensation received from carrier: _____

Sr. No.	Item Purchased/ Items Lost	Date of Purchase	Cost in Foreign Currency (In INR for loss claim)
Total:			
Compensation From Airlines:			
Net Amount:			

Documents to be submitted in support of the claim for Checked-in Baggage Loss:

- Statement of claim furnishing the details of items contained in the Checked-In Baggage and the values thereof (excluding Valuables). Values of the items shall represent their market value after allowing for age and usage.
- Property irregularity report issued by the Common Carrier.
- Voucher of the Common Carrier for the compensation paid for the non-delivery/ short delivery of the Checked-In Baggage.
- Copies of correspondence exchanged, if any, with the Common Carrier in connection with the non-delivery/ short delivery of the Checked-In Baggage.
- In case of items of individual value equal to or more than US\$ 100 contained within the Checked-In Baggage, proof of ownership in the form of purchase bill (or any other proof to the satisfaction of the Assistance Service Provider).

In case of compensation from the Common Carrier having been received after payment of the claim by the Company hereunder, the Insured shall repay to the Company such amount in excess of his/ her loss after taking into account the amount of claim received from the Company and at that received from the Common Carrier.

In case the undelivered Checked-In Baggage is subsequently traced by the Common Carrier and offered for delivery to the Insured, the Insured shall take delivery of the Checked-In Baggage and refund the amount paid by the Company hereunder. In case of delivery of part of the Checked-In Baggage, the amount paid by the Company attributable to such Checked-In Baggage shall be refunded by the Insured to the Company.

Documents to be submitted in support of the claim Checked-in Baggage Delay:

- Property irregularity report stating the scheduled time of delivery and actual time of delivery of the Checked-In Baggage issued by the Common Carrier.
- Voucher of the Common Carrier for the compensation paid for the delay in delivery of the Checked-In Baggage.
- Copies of correspondence exchanged, if any, with the Common Carrier in connection with the delay in delivery of the Checked-In Baggage.

Dated: DD/MM/YYYY Place: _____

Claimant's/ Insured's Signature

Annexure 6: PERSONAL ACCIDENT & ACCIDENTAL DEATH (COMMON CARRIER)

Please state circumstances of accident i.e. how, when, where it took place: _____

Nature of Injury: _____

State diagnosis and nature of treatment/ surgery under taken: _____

Provide name, address & telephone number of Hospital/ Clinic: _____

Treating Doctor's Name & Qualifications: _____

Treating Doctor's Telephone Number: (O) _____ (M) _____

Dates of treatment: From DD/MM/YYYY To: DD/MM/YYYY

Attending Doctor's Report

Date doctor contacted: DD/MM/YYYY Time: HH:MM

Nature of Ailment: _____

State diagnosis and nature of treatment provided: _____

Describe any other disease or infirmity affecting present condition: _____

Was the accident due to Pregnancy: Yes No

Was the accident due to any pre-existing condition: Yes No If yes, please give details: _____

Can the patient be evacuated back to the Republic of India? Yes No

Loss Incurred (Please tick):

Death

Permanent Total Disability: (Details) _____

Permanent Partial Disability: (Details) _____

Documents to be submitted in support of the claim:

1. Medical reports giving the details of the Accident, nature of Injury and the extent of disability.
 2. In case of death of the Insured, death certificate issued by the Medical Practitioner who attended on the Insured.
 3. Postmortem certificate to be produced if required by the Assistance Service Provider.
- Police report in original in case the Accident shall have taken place in a public place or premises.

Dated: DD/MM/YYYY Place: _____

Claimant's/ Insured's Signature

Annexure 7: HIJACK DISTRESS ALLOWANCE

Name of Carrier:
Port of Hijack:
Port of Release:
Dates of Hijack: From: / / / / / To: / / / / /
Time of Hijack: From: : :

Documents to be submitted in support of the claim:

Certificate of Hijack from the aircraft/ ocean going vessels furnishing details of travel by the Insured, the fact of his/ her being held captive and confirmation of death, if death shall occur.

Dated: / / / / / Place:

Claimant's/ Insured's Signature

Annexure 9: HOME INSURANCE

Address of property where loss was sustained: _____

Date of Loss: / / / / / / / /

Cause of Loss: _____

Exact description of nature of loss and it causes (in case of burglary, how was forceful entry gained into the premises and who is suspected of the same):

Occupants of the premises at the time of loss/ by whom it was discovered: _____

Has the loss been reported to the proper authorities? Yes No Please give details of where and to whom the loss has been reported along with the date and time (If not reported, please give reasons for the same): _____

Details of any other insurance cover for the property: _____

Details of Loss Incurred:

Sr. No.	Items lost due to fire/ burglary	Amount
Total		

Documents to be submitted in support of the claim

1. First Information Report
2. Panchnama
3. Investigation Report by the Police
4. Fire Brigade Report
5. Estimate and final bills of repairers
6. Invoices of owned articles, if required by the Company
7. Legal opinion wherever required
8. The statement of claim furnishing the details of items lost and the values thereof duly supported by purchase bills wherever available. In the event of the purchase bills not being available, he/ she shall render such evidence as may be required by the surveyor for the latter to arrive at the value of the lost items.
9. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy.

Dated: / / / / / Place: _____

Claimant's/ Insured's Signature

Annexure 10: TRIP CANCELLATION & INTERRUPTION

Trip Cancelled/

Trip interrupted/

Also claiming for Trip Regained

Reason for Trip Cancellation/ Interruption: _____

Please detail out the above reason for trip cancellation/interruption (how, where, when and reason for the same):

Trip Cancellation/ Interruption date: / /

Original Travel Dates: From: / / Time: :

Person Affected and Relationship with the Insured: (If not the Insured, please also provide address and contact details) _____

Details of Losses/ Expenses Incurred:

Sr. No.	Loss/ Expenses Details	Amount
Total:		

Documents to be submitted in support of the claim:

1. In case of cancellation of the Trip either in the Country of Residence of the Insured or any other intermediate place forming part of the Trip by the Common Carrier solely resulting from contingencies namely Earthquake, Storm, Flood, inundation, cyclone, tempest & Terrorism, duly completed claims form to be accompanied by:
 - a. Confirmation of cancellation of the Trip from the Common Carrier detailing the circumstances of cancellation;
 - b. Original used air ticket indicating the cost the ticket and receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the Trip the cancellation charges retained;
 - c. Original bill and a receipt/ letter obtained from the hotel and/ or guest house and/ or any other paid residential accommodation (available for fee) indicating the amount paid for the accommodation, the refund given and the cancellation charges retained, wherever such accommodation has be arranged at the place of cancellation of the Trip;
 - d. Used air ticket in original for return journey from the place of cancellation to the Country of Residence of the Insured which indicate the cost of the tickets together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip.
2. In case the cancellation of the Trip shall result because of personal contingencies covered hereunder or a decision taken at the instance of the Insured arising out of the contingencies namely Earthquake, Storm, Flood, inundation, cyclone, tempest & Terrorism, the duly completed claims form to be accompanied by:
 - a. Medical evidence as may be required by the Assistance Service Provider in case of the cancellation of the Trip arising out of personal contingencies of the Insured or his/ her Immediate Family;
 - b. Receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the Trip indicating the cancellation charges retained;
 - c. Receipt/ letter obtained from the for the hotel and/ or guest house and/ or any other residential accommodation (available for a fee) indicating the cancellation charges retained, wherever such accommodation has be arranged at the place of cancellation of the Trip;
 - d. Used air ticket or boarding pass in original for return journey from the place of cancellation to the Country of Residence of the Insured together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip.
3. In case the cancellation charges either for the Trip or part of it or in relation to the accommodation in a hotel/ guest house/ other residential accommodation is waived to the advantage of the Insured subsequent to any settlement of claim under this Benefit, the Insured shall forthwith return the sum paid by the Company to the extent of such waiver.

Dated: / / Place:

Claimant's/ Insured's Signature

Annexure 19: BAIL BOND

Name and contact details of the detaining authority: _____

The offense for which the insured is in custody: _____

Is this offense bailable as per the laws of the country? Yes No

Please attach the court order stipulating the required amount as bail bond. Please attach more sheets to give details, if necessary.

Dated: / / Place: _____

Claimant's/ Insured's Signature

Annexure 20: SPONSOR PROTECTION

Name of the sponsor: _____

Cause of accident causing the demise of the sponsor: _____

Nature of injury causing the demise of the sponsor: _____

Place of accident of the sponsor: _____

Name, address and telephone number of hospital/ clinic where treatment was given to the sponsor: _____

Name of treating doctor of the sponsor: _____

Details of medical/ surgical treatment given to sponsor: _____

Dates on which the sponsor was given medical/ surgical treatment: From: / / To: / /

Please attach medical reports, doctor's statement giving the details of the sponsor and cause of death, and the death certificate of the sponsor. Medical statements from relations/ spouse will not be accepted. Please attach more sheets to give details, if necessary.

Tuition fees Claimed: _____

Dated: / / Place: _____

Claimant's/ Insured's Signature

Annexure 21: STUDY INTERRUPTION

Due to hospitalisation of the insured

Name, address and telephone number of hospital/ clinic where treatment is being given: _____

Name of treating doctor: _____

Details of ailment: _____

Cause of the ailment: _____

Was the ailment/ incident caused due to/ aggravated due to a pre-existing condition? Please give details: _____

Date of onset of ailment: / / Nature of treatment: _____

Dates of hospitalisation: From: / / To: /

Reason for medical evacuation (if applicable): _____

Reason for not continuing studies abroad: _____

Tuition fees paid in advance for the year: _____

Due to death of sponsor or immediate family member

Name of the sponsor/ immediate family member: _____

Cause of accident causing the demise of the sponsor/ reason for death of immediate family member: _____

Nature of accident causing the demise of the sponsor: _____

Place of accident of the sponsor: _____

Name, address and telephone number of hospital/ clinic where treatment was given to the sponsor/ the immediate family member: _____

Name of treating doctor: _____

Details of medical/ surgical treatment: _____

Dates of medical/ surgical treatment: From: / / To: /

Reason for not continuing studies abroad: _____

Tuition fees paid in advance for the year: _____

Please attach medical reports, statements from the treating doctor and death certificate as proof of the above. Medical statements from relations or spouse will not be accepted. Please also attach the receipts of the university fees paid. Please attach more sheets to give details, if necessary.

Dated: / / Place: _____

Claimant's/ Insured's Signature



Mailing Address: ICICI Lombard General Insurance Company Limited, Interface Building No.11, 401/402 4th Floor, New Link Road Malad (W), Mumbai - 400 064.

Registered Office Address: ICICI Lombard General Insurance Company Limited, ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.

Visit us at www.icicilombard.com • Mail us at customersupport@icicilombard.com

Toll Free No.: 1800 2666 • Chargable No.: +91 92236 22666 • SMS Facility "HEALTHCLAIM" to 575758

ICICI Lombard General Insurance Company Limited. Insurance is the subject matter of the solicitation. IRDA Reg. No. 115. Misc 29, Misc 50, Misc 129.