Domestic Travel Insurance — Claim Form

TATA AIG INSURANCE
WITH YOU ALWAYS

IMPORTANT:

Please contact our 24-hour helpline (our Assistance Center) on 1800-266-7780 or 022-6693 9500

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 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: D D M M Y Y Y Y to: D D M M Y Y Y Y

DETAILS OF PATIENT / INSURED PERSON

Name

Permanent Address

City

State PIN

Phone (O) (R)

Fax Mobile

E-mail

Date of Birth: D D M M Y Y Y Y Sex: M F

Assistance Company Ref No.: Passport No.:

Date of Departure: D D M M Y Y Y Y Flight No. _____ From _____ to _____

Date of Arrival: D D M M Y Y Y Y Flight No. _____ From _____ to _____

Please indicate whether claim is in respect of: Accident & Sickness Travel Delay Baggage Loss Baggage Delay Trip Cancellation / Trip Interruption

Please complete the Section relevant to your claim.

LOSS/DELAY 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 Airline Reference No. _____

Details of compensation received from carrier: _____

Scheduled date/time of Arrival: D D M M Y Y Y Y ; : hrs.

Actual date/time when bags delivered: D D M M Y Y Y Y ; : 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.*

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TRIP CANCELLATION / TRIP INTERRUPTION

Flight No. _____ Date D D M M Y Y Y Y From _____ to _____

Scheduled time of Departure: _____ hrs. Cause for Cancellation/Interruption : _____

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

Details of Expense Incurred	Date	Place	Amount
Amount refunded by Common Carrier and Hotel			
		TOTAL	

TRAVEL DELAY

Flight No. _____ Date D D M M Y Y Y Y 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	

ACCIDENT MEDICAL BENEFIT

If accident, details of accident i.e. how, when, where it took place: _____

_____

_____

Date: D D M M Y Y Y Y Place: _____

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DETAILS OF ACCIDENTAL MEDICAL EXPENSES

Details of treatment	In/Out Patient		Charges	Status of Payment
	From	To		Paid/Outstanding
			Paid	
			Outstanding	
			TOTAL	

Whether Assistance Co. was contacted: Yes ☐ No. ☐ If Yes, Reference No._____

_____

_____

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: D D M M Y Y Y Y

Place: _____ Signature of insured :_____

ATTENDING DOCTOR'S REPORT

Patient Name

Age ☐☐ Marital status: Married ☐ Single ☐

Address

City

State PIN

Phone (O) (R)

Fax Mobile

Date of contacted: D D M M Y Y Y Y Time: ☐☐ A.M. ☐☐ P.M.

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FOR ACCIDENTAL INJURY

Nature of Injury : _____

_____

X-Ray taken: Yes ☐ No ☐ Date taken: D D M M Y Y Y Y

Diagnosis and Treatment given: _____

_____

Describe any other disease or infirmity affecting present condition: _____

_____

_____

_____

Signature: _____
Attending Doctor's Signature

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Tata AIG General Insurance Company Limited
Registered office: Peninsula Business Park, Tower A, 15th Floor, G. K. Marg, Off Senapati Bapat Road, Lower Parel, Mumbai - 400 013.
For more information visit us at; Email us at customersupport@tata-aig.com or visit www.tataaiginsurance.in
Contact us on our 24 hour Toll Free Helpline at 1800 266 7780 or 1800 22 9966 (only for senior citizen policy holders)
Insurance is the subject matter of the solicitation