

Nature of Ailment: _____

State diagnosis and nature of treatment provided: _____

When did patient's symptoms first appear? _____

Describe any other disease or infirmity affecting present condition: _____

Was the ailment due to Pregnancy: Yes No

Was the ailment aggravated 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

Medical Doctor's Signature and Date: _____

Claiming also for daily allowance

Medical Treatment Expenses Details

Sr. No.	Details of medical treatment/ medical evacuation/expenses	Date	Expenses in Foreign Currency / INR

The above information is just a summary report of the incident .Please attach more sheets to give details if necessary. The claim form should be accompanied with bills / vouchers/ reports / discharge summary , and they must mention the person treated , type of ailment details of individual items of medical treatment provided and dates of treatment , Along with prescription and original bills related to Charges paid towards Hospital accommodation, nursing facilities and other medical services rendered; Fees paid to the Medical Practitioner, special nursing charges, etc; Charges incurred towards any and all test and / or examinations rendered in connection with the treatment. The medicines prescribed and the receipt stamp of the pharmacy. Treatment taken on different dates of separate ailments will be treated as separate medical claims where standard deductibles will be applicable for each claim.

NOTE: In respect of all claims payable hereunder, the Company may effect settlement either in the form of cashless treatment facility or by reimbursement of the amount of claim to the Insured, at its sole discretion. Cashless treatment facility cannot be demanded by the Insured as a matter of right.

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 treatment/expenses	Date	Expenses in Foreign Currency / INR

Please attach the 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, and further provide the proof for expenses incurred towards disposal of

the mortal remains, and 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.

Checked-In Baggage Loss/Delay:

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

State the extent of Delay / Loss: _____ Place of Delay / Loss: _____

Name the common carrier: _____ No. of Hours of bag delays: _____

Flight Details:

1. Flight No.: _____ From: _____ To: _____

2. Flight No.: _____ From: _____ To: _____

Actual Date & Time of Arrival of flight at Port:

Actual Date & Time when Bags were delivered:

Had the common carrier been notified at the time of loss? Yes No

Property Irregularity Report (PIR) number from Airline/ Common Carrier: _____

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 Airline			
Net Amount			

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

1. Statement of claim furnishing the details of items contained in the Checked-In Baggage.
2. Property irregularity report issued by the Common Carrier.
3. Voucher of the Common Carrier for the compensation paid for the non-delivery / short delivery of the Checked-In Baggage.
4. 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 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:

1. Property irregularity report stating the scheduled time of delivery and actual time of delivery of the Checked-In Baggage issued by the Common Carrier;
2. Voucher of the Common Carrier for the compensation paid for the delay in delivery of the Checked-In Baggage;

3. Copies of correspondence exchanged, if any, with the Common Carrier in connection with the delay in delivery of the Checked-In Baggage.

Loss of Passport

Date of Loss: / /

Place of Loss: _____

Sr. No.	Expense Details	Amount

Documents to be submitted in support of the claim Loss of Passport:

1. Police report obtained within 24 hours of becoming aware of theft
2. Bills / Vouchers of expenses incurred in obtaining a fresh / duplicate passport.

Personal Accident

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) _____

Room / Ward / Bed Number: _____

Dates of treatment: From / / To: / /

Attending Doctor's Report

Date doctor contacted: / / Time: / /

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 and Partial Disability: (Details) _____

Medical Doctor's Signature and Date:

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

Documents to be submitted in support of the claim:

1. In case of cancellation of the Trip either in the City 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, fog (if specifically covered) 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 City 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, fog (if specifically covered) the duly completed claims form to be accompanied by:
 - a) A declaration from the Insured furnishing the circumstances that compelled him / her to cancel the Trip;
 - b) 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;
 - c) Receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the Trip indicating the cancellation charges retained;
 - d) 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;
 - e) Used air ticket or boarding pass in original for return journey from the place of cancellation to the City 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.

Trip Delay

Reason for Trip Delay: _____

Please detail out the reason for trip delay (how, where, when, what was lost and reason for the same):

Original Travel Dates: From:

To:

Trip delayed on:

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

Details of Expenses Incurred:

Sr. No.	Loss / Expenses Details	Amount

Please attach confirmation of delay of the Trip from the Common Carrier detailing the circumstances of delay, in case of delay of the Trip, at any places forming part of the Trip, by the Common Carrier solely resulting from contingencies namely earthquake, storm, flood, inundation, cyclone, tempest & terrorism, fog (if specifically covered)

Missed Connection

Original Travel Schedule: (Please give date and time of all flights, mentioning the original and actual arrival and departure times.

Please also mention the name of carriers and flight numbers) _____

Which flight was delayed causing a missed connection? _____

Reason for delay of the flight: _____

Details of expenses due to Missed Connection:

Sr. No.	Expenses	Amount

Please attach the confirmation from the Common Carrier of the delayed flight as to the expected time of arrival and the actual time of arrival at the port of delay together with the reasons for delay, and the unused ticket for the ongoing flight (Missed Flight) with an endorsement of the Common Carrier of cancellation of the same, and Original used ticket obtained afresh towards the alternative flight for the part of the Trip covered by the Missed Flight indicating the amount paid as fare. Further the Certificate from the Common Carrier of the Missed Flight that the fare for the part of the Trip covered by the Missed Flight is forfeited in full or in part together with the amount of forfeiture.

Compassionate Visit

Person Hospitalized: Insured Family Member

Name of the person hospitalized (if not the insured): _____

Relationship with the insured: _____

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

Treating Doctor's Name & Qualifications: _____

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

Room / Ward / Bed Number: _____

Dates of hospitalization: From: D | D | M | M | Y | Y | Y | Y |

To: D | D | M | M | Y | Y | Y | Y |

Date of onset of symptoms: D | D | M | M | Y | Y | Y | Y |

Attending Doctor's Report

Date doctor contacted: D | D | M | M | Y | Y | Y | Y |

Time: H | H | M | M |

Nature of Ailment: _____

State diagnosis and nature of treatment provided: _____

When did patient's symptoms first appear? _____

Describe any other disease or infirmity affecting present condition: _____

Was the ailment due to Pregnancy: Yes No

Was the ailment aggravated 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

Estimated time the patient would continue to be in the hospital? _____

Medical Doctor's Signature and Date: _____

Expenses Details

Sr. No.	Details of expenses	Date	Expenses in Foreign Currency / INR

Please attach a certificate from the Medical Practitioner recommending the presence in the form of special assistance to be rendered by a member of the Family or near relative during the entire period of Hospitalization. Certificate to also specify the minimum period of Hospitalization and discharge summary of the Hospital furnishing details – date of admission, date of discharge, and the presence of the member of the Family or near relative on all days of Hospitalization original ticket used for the travel to and fro by the member of the Family or near relative.

For any claim related to/on account of any Accident or Personal Liability

Please describe the incident: _____

Date of Injury: D | D | M | M | Y | Y | Y | Y |

Are you Attorney represented for this Injury? Yes/No if yes, complete below:

Attorney Name: _____ Law Firm Name: _____

Phone: _____ Address: _____

<input type="checkbox"/> Vehicular Accident Type of Vehicle: _____ <input type="checkbox"/> Single Vehicle Accident <input type="checkbox"/> Multiple Vehicle Accident Vehicle Insurance Information for patient: Driver Name: _____ Policyholder Name: _____ Insurance Co. Name: _____	<input type="checkbox"/> Premises Injury Homeowner or Business Name: _____ Address: _____ Phone: _____ Insurance Co. Name: _____ Address: _____
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Address: _____ Adjuster's Name: _____ Adjuster's Phone: _____ Claim Number: _____ Did you rent a car? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Owner (Rental Company): _____ Location of Rental: _____ Important! Please provide a copy Rental Receipt and/or Agreement. Vehicle Insurance Information for Other Party: Driver Name: _____ Policyholder Name: _____ Insurance Co. Name: _____ Address: _____ Adjuster's Name: _____ Adjuster's Phone: _____ Claim Number: _____	Adjuster's Name: _____ Adjuster's Phone: _____ Claim Number: _____ <input type="checkbox"/> Product Injury Product Name: _____ Company Name: _____ Insurance Co. Name: _____ Address: _____ Adjuster's Name: _____ Adjuster's Phone: _____ Claim Number: _____ <input type="checkbox"/> Other Injury Please describe (Attach separate sheet if necessary) _____ _____ _____
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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 people 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 hereunder 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.

Place: _____
 Date: _____

Signature of the claimant _____

All information received as a result of this release will not be disseminated to any other entity without the expressed written authorization of the Plan participant, or The Member, if the Participant is a minor. This authorization is valid for one year from the date of signature.

*Please read the policy wordings for detailed requirements of documents ICICI Lombard General Insurance Company Ltd. Insurance is the subject matter of the solicitation MISC 110