

# HDFC ERGO General Insurance Company Limited

## Overseas Travel Insurance Claim Form

(To be filled in by the Insured Policyholder or Insured's Representative duly authorised by Power of Attorney. Issuance of this claim form is not to be taken as an admission of liability. Please attach all bills, receipts, credit card slips pertaining to your claim)



Please contact our 24x7 helpline in respect to any claims settlement request. New Contact Details for Travel Claims.

Toll Free No - ISOS 186-620-24700 (Only for USA & Canada) Email ID - hdfcergo@internationalsos.com	Landline - 91 11 41898872 (For countries other than USA & Canada)
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POLICY/CERTIFICATE NO. \_\_\_\_\_ Period from: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Passport No \_\_\_\_\_ Trip Destination \_\_\_\_\_ Claims Ref No \_\_\_\_\_

### DETAILS OF INSURED

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex  Male  Female

Current Address \_\_\_\_\_

Phone No. (Res) \_\_\_\_\_ Email Id. \_\_\_\_\_

Permanent Address \_\_\_\_\_

Phone No. (Off) \_\_\_\_\_ Phone No. (Res) \_\_\_\_\_

Does the insured have any other Health/Accident or Travel Insurance ? If yes, please give details below:

Name of Insurer \_\_\_\_\_ Policy Number \_\_\_\_\_

Date trip commenced \_\_\_/\_\_\_/\_\_\_ Schedule date of return \_\_\_/\_\_\_/\_\_\_

### CLAIMANT INFORMATION (If different than "Insured Information" above, Name and Age of each person included in the claim)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Claimant's Address \_\_\_\_\_

Phone No. (Off) \_\_\_\_\_ Phone No. (Res) \_\_\_\_\_ Relationship with the Policyholder \_\_\_\_\_

In what capacity are you making this claim? \_\_\_\_\_

Please indicate whether claim is in respect of ( Tick Boxes)

- Accidental Death  Permanent Disablement  Emergency Medical Expenses & Medical Transport/Evacuation  Emergency Dental Benefits  Hospital Cash - Accident Only  
 Body Repatriation (Related to Death Cover)  Emergency Travel Expenses for Family Members  Emergency Travel Expenses for Replacement Colleague  Emergency Hotel Extension  
 Emergency Hotel Accommodation  Loss of Baggage & Personal Documents  Loss of Checked in Baggage  Delay of Checked in Baggage  Flight Delay  Hijacking  
 Trip Cancellation (Cancellation of to & Fro Journey)  Trip Interruption (Cancellation of Return Journey)  Personal Liability  Loss of Cash  Other (Pls specify)

### AUTHORIZATION

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. I understand this information will be used by HDFC ERGO General Insurance, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. 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. I agree that this authorization shall be valid for the duration of this claim.

I also authorize services provider of HDFC ERGO to obtain any medical records or information to process this claim.

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.

PLACE \_\_\_\_\_ DATE \_\_\_/\_\_\_/\_\_\_

SIGN (Claimant or authorized person)

N.B. Please complete appropriate section of Claim Form and read carefully the instructions relating to supporting documents required. When completed please sign declaration above

### Section A – Accidental Injury Form (Claimant's Statement)

Date of accident \_\_\_/\_\_\_/\_\_\_ Time \_\_\_\_\_ Place of Accident \_\_\_\_\_

Please describe in detail the circumstances of accident (attach separate sheet if needed)

Please describe the nature of Insured's injuries

Please list the names and addresses of all treating physicians and hospitals:

Name	Street Address	City	State	Pin Code	Phone

Did police or other authorities investigate the accident? \_\_\_\_ If yes, please provide name, address and telephone number of all investigating officers and agencies:



**Section D - Checked Baggage Loss/ Baggage Delay/ Baggage and Personal Document Loss Information**

Date of loss, damage or delay \_\_\_\_/\_\_\_\_/\_\_\_\_

Time of day \_\_\_\_\_ a.m \_\_\_\_\_ p.m

Please describe in detail where and how the loss, damage or delay occurred

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Please describe in detail the nature and extent of loss, damage or delay

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Was loss, damage or delay occurred while insured property was on or in the custody of a common carrier (e.g., railroad, airline, cruise ship, bus, taxi, etc.)?  Yes  No

If yes, please complete the following

Name of carrier \_\_\_\_\_ Flight, trip or tour number \_\_\_\_\_

Was the carrier notified at the time of loss or damage?  Yes  No

If yes, please identify where, when and to whom (name and title) notification was given

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Was extra valuation of the property declared? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Was the baggage checked at the time of loss or damage?  Yes  No

If yes, please enclose claim check

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Has formal claim been filed against the carrier?  Yes  No

If yes, has payment been made to you?  Yes  No If yes, amount received? \_\_\_\_\_

Do you have any other insurance that may provide coverage for this accident or loss?  Yes  No

If yes, please identify the name, address and policy number of all other insurance including Homeowners Travel club, credit card etc

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Has the claim been filed?  Yes  No

If yes, what is the current status of that claim?

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Was loss reported to police or other authorities?  Yes  No

If yes, please identify where, when and to whom (name and title) loss was reported

Case # \_\_\_\_\_

Valuation of lost and/or damage property

Sr.No	Description	Date and place of Purchase	Original Cost	Replacement Cost or Estimated	Amount Claimed
1					
2					
3					
4					
5					
6					
7					

(attach bills of sale, receipts or estimates)  
Are any claims items used in your business/ occupation or profession? \_\_\_\_\_. If yes, identify the items by \* above

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PLACE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

SIGN (Claimant or authorized person)

**Section E - Flight Delay/ Flight Cancellation Claim Information**

Name of the common carrier \_\_\_\_\_

Flight No \_\_\_\_\_ From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_ a.m./ p.m.

Please describe in detail the nature and extent of loss, damage or delay

Was loss, damage or delay occurred while insured property was on or in the custody of a common carrier (e.g., railroad, airline, cruise ship, bus, taxi, etc.)?  Yes  No

If yes, please complete the following

Name of carrier \_\_\_\_\_ Flight, trip or tour number \_\_\_\_\_

Was the carrier notified at the time of loss or damage?  Yes  No

If yes, please identify where, when and to whom (name and title) notification was given

Was extra valuation of the property declared? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Was the baggage checked at the time of loss or damage?  Yes  No

If yes, please enclose claim check

Has formal claim been filed against the carrier?  Yes  No

If yes, has payment been made to you?  Yes  No If yes, amount received \_\_\_\_\_

Do you have any other insurance that may provide coverage for this accident or loss?  Yes  No

If yes, please identify the name, address and policy number of all other insurance including HomeownersTravel club, credit card etc

Has the claim been filed?  Yes  No

If yes, what is the current status of that claim? \_\_\_\_\_

**DETAILS OF EXPENDITURE INCURRED**

Sr. No	Description	Date	Place	Amount
1				
2				
3				
4				
5				
6				
Total				

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

PLACE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

SIGN (Claimant or authorized person)

**Claims not falling in the above mentioned sections**

Type of claim \_\_\_\_\_

Incidence of claim description \_\_\_\_\_

Place of loss \_\_\_\_\_ Date of loss \_\_\_\_/\_\_\_\_/\_\_\_\_ Claimed amount \_\_\_\_\_

Claim Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

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.

PLACE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

SIGN (Claimant or authorized person)

# HDFC ERGO General Insurance Company Limited



## Consent for Mode of Claim Payment

Name of Insured

Policy Number

Claim Number

Beneficiary Name

Mode of Payment Cheque  Fund Transfer

(Please tick for mode of payment)

(All Fields are Mandatory in case of Fund Transfer)

Insured's Name as per Bank Account

Bank Account Number

Branch Name

IFSC Code

Email address

Attachments  
In Support of Bank Details  
(Please tick the type of proof submitted)

Cancelled Cheque

Bank Passbook Copy

Declaration: I Mr./ Mrs/ Ms. \_\_\_\_\_

undersigned, legal beneficiary of the above claim, declare that all details mentioned in this form are true and I agree to the mode of payment against the particular claim number mentioned above.

Signature of Beneficiary

Stamp Required in case of Company

Date: