TATA-AIG GENERAL INSURANCE COMPANY LIMITED



OVERSEAS TRAVEL INSURANCE CLAIM FORM

For Accident / Sickness Medical Expenses Reimbursement Only

IMPORTANT:

Please contact our 24-hour helpline (our Assistance Center) on

For the Americas Policies:+ 866-866-2619/+1-817-826-7017

Email: tata.aig@aig.com.

For rest of the world policies excluding the Americas:Ph: +603 - 2118 - 0782 / +603 - 2118 - 0784

Email: TGAP.TATAmedical@travelguard.co Failure to call our Assistance Company on 24-hour he	m			
Failure to call our Assistance Company on 24-hour he if any.	Ipline, in respect of Medical Acc	ident & Sickness C	laims shall invalidate your cla	aim,
This is a One Call Claim Form, except for Accidental De	eath & Dismemberment (ADD), For	ADD, we shall provide	de a separate Claim Form upon	notification.
Issuance of the form is not an admission of liability or a No claim under Accident & Sickness Section will be add Please answer all questions completely. In case of insu	waiver of terms, conditions & exce	eptions of the insuran	ce contract.	
3. No claim under Accident & Sickness Section will be add	mitted without Doctor's Report as p	er format (Attending	Doctor's Report - Page 3)	
4. Please answer all questions completely. In case of insu	ıfficient space, please attach an ad	ditional sheet.		
Please attach all Original bills& receipts pertaining to yo	our claim.			
Insurance Card No. / Payana No	Period From		_ to:	
	DETAILS OF PATIEN	T/ INSURED PE	RSON	
Name of the Insured :-				
Name of the Employee :	[Employee No.		_
Name of the Claimant :	P	hone Nos		
Permenant Address (INDIA):				
Bank Account Name (in INDIA) :		Acco	ount NAME.:	
Bank Account No.:		<u> </u>	IFSC Code	
Name of the Bank & Address :				
Account NAME.:				
Email Id :				
Date of Birth:/		ex: M/F		
Assistance Company Ref No.:	Р	assport No.:		
Date of Departure:// Fligh	nt No F	rom	to	
		rom		
	<u>-</u>			
MEDICAL ACCIDENT A CICKNESS DENI		. / /	IOMESS BENEAU BELL	== / =N=D == N=N N N = D 0 A
MEDICAL ACCIDENT & SICKNESS BENE		H / DIM / RIMR/ SI UTAION	ICKNESS DENTAL RELI	EF / EMERGENCY MEDICAL
If accident, details of accident i.e. how, when,	where it took place:			
Date:	Place:			
If sickness, state nature and diagnosis, and ac		ms first occurred	·	
 Date:	Diago			
	_ Place:			
Name & Address of consulting physician:				
Have you ever been treated for this illness before the provide name & address of consulted place.	ore: LY	es 🗆 No		
Provide name & address of your family physici	an·			
Provide name of any prescription medicine you	u are presently taking:			
Indicate other health insurance coverages, inc		y number & certi	ficate number of insurer:	
		RIZATION		-

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: Place:

ETAILS OF MEDICAL EXPENSES					
Details of treatment	In/ Out Pa	tient	Charges (Currence	y) :	Status of Payment
	From		Eg : USD / EURO		Outstanding
	<u> </u>			Paid	
			Outst	nding	
_			'TO	ΓAL	
/hether Assistance Co. was contacted: Yes	No. If Yes, Referen	ce No			
No, give reasons:					
	Attending Do	ctor's Report			
Patient's Name:		Age:	Sex:	M/F	
ddress:					_
ate contacted:	Time:				
ature of Injury/ sickness :					
Details of incidence					
Diagnosis and Treatment Given:					
					_
					 - -
When did patient's symptoms first appear: Describe any other disease or infirmity affecting prese					
Describe any other disease or infirmity affecting prese	ent condition:				 - -
Describe any other disease or infirmity affecting prese	ent condition:				 - -
escribe any other disease or infirmity affecting prese	ent condition:				
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Attending Doctor's Signature: Attending Name: address: Attending Place of Death:- IR No:-	ent condition:	existing condition	on: Yes □lo	_	
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 Flight No 	From	to)	<u> </u>
Flight No	From	to)	
	been notified at the time of loss?	Yes□ No □	Airline Reference No	
	received from carrier:	A street data /times rule and h	and delivered . / /	
No. of Hours delayed :_	Arrival:/;:hrs.	Actual date/time when b	ags delivered :/;;	nis
	urchased/Lost *	Date of Purchase	Place	Cost
	11 0114004/2001	Date of Farenass	1 1000	
			TOTAL	
	Less Compensation received	d from Airline:	Not Amount	
			Net Amount:	
	ovide details of purchases made			
* In case of Loss, please pro	ovide details of Items lost.			
		LOSS OF PASSPOR	T	
Places provide details o	f the incident i.e. when, where an			
riease provide details o	i the incident i.e. when, where an	d flow it flappelled		
Details of Police Report	(please attach copy): No:	Date:	Place:	
	Expense incurred	Date	Place	Amount
2014			1.000	7
			TOTAL	
		TRAVEL DELAY/ FLIGHT [
Flight No		From	to	
	rture: Actual time		No. of Hours delayed:	
	& boarding provided by carrier: Y		Diese	A
Details of	Expense incurred	Date	Place	Amount
			TOTAL	
	TRIP CANCELLA	TION / TRIP INTERRUPTIO		
Flight No.		From	to	
Scheduled time of Depa	rture: Cause for C	Cancellation / Interruption/ co	urtailment :	
Details of	Expense incurred*	Date	Place	Amount
A management of the state of the	Common Comics			
Amount refunded by	y Common Carrier and Hotel		TOTAL	
*Diagon mate that this age		les to Illaco Inicas on death	TOTAL	on Von Land diete Englis
1 rease note that this cov	verage applies if Trip is cancelled of	PERSONAL LIABILIT		on, rour ininiculate Family
Diagga provide detaile e	f injury/ property damaged:	PERSONAL LIABILIT	1	
riease provide details o	i injury/ property damaged			
Have you received a lec	al notice, if Yes ,please furnish a	copy (Yes/ No)		
a.o you rooorvou a leg	,	55pj (100/110)		
	BOUNC	ED BOOKING OF HOTEL	AND AIRLINES	
Flight No			to	
Scheduled date of book	ing: Cause for boo	unced booking at hotel / airl	ine :	
i		-		

Details of Expense incurred*	Date	Place	Amount
Amount refunded by the airline/ hotel		TOTAL	
		TOTAL	
	D DEPARTURE/ MISSED C	ONNECTION	
Flight No Date//	From	to	
Scheduled time of Departure: Actual time Whether accomodation & boarding provided by carrier: Y	of Departure:	No. of Hours delayed:	
	esNo Date	Place	
Details of Expense incurred	Date	Place	Amount
	HIJACKING	TOTAL	
	HIJACKING		
Flight Details: No From		to	
Scheduled Date & time of Departure:	Scheduled date & ti	me of arrival:	
Data and time of Hillinghy	Data 8 times Datumando		
Date and time of Hijack:	_ Date & time Returned:		-
Please provide details of incident:			
0.110	FRADULANT CHARGE	S	
Card NO:-	Date of Lost Card :-		
Date & Time when the lost card inform to card issuer :- FIR Details :-			
Card Details :-			
Details of charges made on lost card			
Cash advances made on card if any			
caon advances made on said ii any			
	HOME BURGLARY	=:0.49	
Incident Details		FIR / Panchaname no :	
Please provide details of the incident i.e. when, where ar	nd how it happened:		
·	nd how it happened:		
Please provide details of the incident i.e. when, where ar Estmiated Loss Details:-	nd how it happened:		
·	nd how it happened:		
·	nd how it happened:		
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Estmiated Loss Details :-		d that I have not withhold any r	playant information which might
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