ICICI Lombard
Aapka Plan B

CLAIMS FORM FOR OVERSEAS TRAVEL INSURANCE

Claim No.: For office use only

Name of insured :

*Email Id :

Contact No. In India : *Mobile No. : Landline No. :

While Traveling Abroad :

Policy Start Date : D D / M M / Y Y Y Y Policy End Date : D D / M M / Y Y Y Y

**Kindly provide the details to enable us to serve you better

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

MEDICAL EXPENSES

Name, address and telephone number of hospital / clinic where treatment was given :

Name of treating doctor :

Details of ailment :

Cause of the ailment :

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

Date of onset of ailment : D D / M M / Y Y Y Y

Nature of treatment :

Dates of treatment : From D D / M M / Y Y Y Y To D D / M M / Y Y Y Y

Is medical evacuation back to the Republic of India needed? Please give detailed reasons of the ailment and reason for transportation :

Details related to previous/concurrent claim Yes ☐ No ☐

If Yes Cashless / Reimbursement /Both

☐ Claiming also for daily allowance

Medical treatment cost details:

Sr. No.	Expense details	Amount

The above information given 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 name of the person treated, type of ailment, details of individual items of medical treatment provided, and dates of treatment, along with prescriptions and original bills, and they must clearly show the medicines prescribed, price and the receipt stamp of the pharmacy. Treatment taken on different dates for seperate ailements will be treated as seperate medical claims, where standard deductible will apply for each claim.

☐ DENTAL TREATMENT

Name, address and telephone number of hospital / clinic where treatment was given :

Name of treating dental surgeon :

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 on set of ailment : D D / M M / Y Y Y Y

Nature of treatment :

Dates of treatment : From D D / M M / Y Y Y Y To D D / M M / Y Y Y Y

Dental treatment cost details:

Sr. No.	Expense details	Amount

The above information given 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, and they must mention the name of the person treated, type of ailment, tooth/teeth treated, details of individual items of medical treatment provided, and dates of treatment, along with prescriptions and original bills, and they must clearly show the medicines prescribed, price and the receipt stamp of the pharmacy. Treatment taken on different dates for seperate ailements will be treated as seperate medical claims, where standard deductible will apply for each claim.

☐ REPATRIATION OF REMAIN

Cause of Death :

Dates of death of insured : D D / M M / Y Y Y Y

Details of expenses incurred for repatriation of remains / funeral :

Sr. No.	Expense details	Amount

Please attach the Official death certificate and a Physician's statement for cause of death. Also, please attach the original bills/receipts of expenses incured.

☐ CHECKED BAGGAGE LOSS

Name of Carrier :

Dates Loss : D D / M M / Y Y Y Y

Place of Loss :

Details of items lost :

Sr. No.	Expense details	Amount

Please attach the Property Irregularity Report, proof of ownership of any items valued in excess of US $ 100, & letter from the airline stating the compensation received for lost baggage. Please attach more sheets to give details if necessary.

☐ CHECKED BAGGAGE DELAY

Name of Carrier : _

Date and Time of Arrival Date : D D / M M / Y Y Y Y Time : H H : M M

Port of Disembarkation : _

Date and Time of Baggage Retrieval : Date : D D / M M / Y Y Y Y Time : H H : M M

Details of Expenses

Sr. No.	Expense details	Amount

Please attach the original bills of emergency items purchased. Please attach more sheets to give details, if necessary. Date & time of receipt of baggage **on the Property Irregularity Report should be specified.**

☐ LOSS OF PASSPORT

Date of Loss : D D / M M / Y Y Y Y

Place of Loss : _

Expenses incurred in obtaining new passport:

Sr. No.	Expense details	Amount

Please attach the police report obtained within 24 hours of becoming aware of theft, and bills / vouchers of expenses incurred in obtaining a fresh / duplicate passport. Please attach more sheets to give details, if necessary.

FINANCIAL EMERGENCY

Date of Loss : D D / M M / Y Y Y Y

Reason of Loss :

Please attach the original police report filed within 24 hours of becoming aware of robbery. Please attach more sheets to give details, if necessary.

PERSONAL LIABILITY

Name of the aggrieved Third party :

Date of Loss : D D / M M / Y Y Y Y

Place of loss :

Reason for loss: (please give details) :

Please attach more sheets to give details, if necessary. Please attach proof of judicial decision rendered by a court of law.

PERSONAL ACCIDENT

Cause of accident :

Nature of injury :

Place of accident :

Name, address and telephone number of hospital / clinic where treatment was given :

Name of treating doctor :

Dates of medical / surgical treatment : From : D D / M M / Y Y Y Y To : D D / M M / Y Y Y Y

Loss incurred : (Please Tick)

Death	
LossorInability to function of	
Anarmatthe shoulder joint:	Anarmtoapoint above the elbow joint:
Anarmbelow the elbow joint:	Aheadatthe wrist:
Athumb:	Anindexfinger:
Anyotherfinger:	Alegabovethe centre of the femur:
Aleguptoa joint below the femur:	Aleguptoa point below the knee:
Aleguptothe centre of the tibia:	Afootatthe ankle:
Abigtoe:	Someother toe:
Aneye:	Hearinginone ear:

Please attach original bills/vouchers/reports/discharge summary and they must mention, name of the person, cause of accident, details of medical treatment and dates of treatment. Please attach more sheets to give details, if necessary. Please attach post mortem report if applicable.

☐ HIJACK DISTRESS ALLOWANCE

Name of Carrier :

Port of Hijack :

Port of Release :

Dates of Hijack : From D D / M M / Y Y Y Y To : D D / M M / Y Y Y Y

Time of Start of Hijack : H H : M M

Please attach police report confirming the incident. It should contain the Passport number of the Insured and Period of hijacking. Please attach more sheets to give details, if necessary.

☐ HOME INSURANCE (Fire & Special Perils, Burglary)

Address of the property where loss was sustained :

City : State: Pin Code:

Date & Time of Loss : D D / M M / Y Y Y Y Time : H H : M M

Nature of loss: (Tick where applicable)

- ☐ Fire
- ☐ Burglary
- ☐ LightningExplosion/Implosion
- ☐ Riot, Strike & Malicious Damage
- ☐ Impact Damage
- ☐ Aircraft Damage
- ☐ Subsidence and Landslide, including rockslide
- ☐ Missile Testing Operation
- ☐ Leakage from automatic sprinkler system
- ☐ Bush Fire
- ☐ Storm, Cyclone, Typhoon, Tempest, Hurricane, Tornado, Flood & Inundation
- ☐ Bursting and/or overflowing of water tanks, apparatus and pipes

Exact description of Nature of loss and its 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 was it discovered :

Have the proper authorities (Fire Brigade & Police) been reported of the loss and by whom? Please give date of time of reporting (if not done, please give reasons):

Details of any other insurance cover for the property :

Details of Items Lost :

Sr. No.	Prescription of Items Loss	Amount

The above information given is just a brief summary of the incident. Please attach more sheet to give details, if necessary. Please attach first information report, investigation report by the police, fire brigade report, Invoices of owned articles (if required by the company), legal opinion wherever required.

☐ TRIP CANCELLATION & INTERRUPTION

☐ Trip Cancelled ☐ Trip Interrupted

Reason for trip cancelled / interrupted: (Tick one)

☐ Illness/Injury ☐ Termination of Employment ☐ Inclement Weather

☐ Losstohome ☐ Abduction/Quarantine ☐ Felonious Assault

☐ TerroristIncident

Date & Time of Incident : D D / M M / Y Y Y Y Time : H H : M M

Person Affected : (Tick one)

☐ Insured ☐ Family Member ☐ Travelling Companion

If not the insured, then please give the following details

Name of Person :

Address of Correspondence :

City : State : Pin Code:

Relationship with Insured :

Details of the reason for trip Cancellation/Interruption (how, where and reasons for the same):

Details of expenses:

Sr. No.	Expense details	Amount

The above information given is just a brief summary of the incident. Please attach more sheet to give details, if necessary. Please attach Medical reports and doctors statement if trip is cancelled or interrupted due to medical reasons. If due to employment reason, then termination letter from the company shall be submitted. If due to other insured events, police report confirming the incident shall be submitted. In case the cancellation or interruption is owing to the sickness, injury or death of a traveling companion, the original tickets of the insured and the traveling companion indicating travel to the same destination for the same dates needs to be submitted. All the bills / receipts of reasonable additional expenses incurred and/or proof of cancellation charges levied by the carriers shall be submitted.

☐ TRIP DELAY

Reason for trip delay (Tick one)

☐ Illness / Injury ☐ Termination of Employment ☐ Inclement Weather

☐ Loss to home ☐ Abduction/Quarantine ☐ Felonious Assault

☐ Terrorist Incident ☐ Delay by Carrier ☐ Loss of passport, travel documents or money

Date & Time of Incident : D D / M M / Y Y Y Y Time : H H : M M

Person Affected: (Tick one)

☐ Insured ☐ Family Member ☐ Travelling Companion

If not the insured, then please give the following details,

Name of Person :

Address of Correspondence :

City : State : Pin Code :

Relationship with Person :

Details of the reason for trip delay (how, where and reasons for the same):

Details of expenses:

Sr. No.	Expense details	Amount

The above information given is just a brief summary of the incident. Please attach more sheet to give details, if necessary. Please attach Medical reports and doctors' statement, or police report confirming the incident causing the trip delay. In case the delay is owing to the sickness, injury or death of a traveling companion, the original tickets of the insured and the traveling companion indicating travel to the same destination for the same dates needs to be submitted. Please also attach all the bills / receipts of reasonable additional expenses incurred.

☐ MISSED CONNECTIONS

Name of Carrier :

Actual Date & Time of Arrival : D D / M M / Y Y Y Y Time : H H : M M

Scheduled Date & Time of Arrival : D D / M M / Y Y Y Y Time : H H : M M

Date & Time of Departure for Connecting Flight : D D / M M / Y Y Y Y Time : H H : M M

Reason for delay :

Details of expenses :

The above information given is just a brief summary of the incident. Please attach morAe sheet to give details, if necessary. Please attach confirmation from the airline, clearly mentioning the scheduled arrival time and the actual arrival time. The reason for delay in the flight also needs to be mentioned. All the bills / receipts of reasonable additional expenses incurred shall be submitted to the Company.

☐ BOUNCED BOOKINGS OF HOTEL / AIRLINES

Name of Carrier / Hotel :

Booking Date : D D / M M / Y Y Y Y

Confirmation date : D D / M M / Y Y Y Y

Reason for bounced booking :

Details of additional expenses:

Sr. No.	Expense details	Amount

The above information given is just a brief summary of the incident. Please attach more sheet to give details, if necessary. Please attach letter from the airline or hotel stating that confirmation was done of the booking and was bounced due to overbooking. The tariff card / original booking confirmation indicating the cost of stay or travel, the cancellation charge applied and the original bills / receipts for the alternative accommodation / travel that were done also needs to be submitted.

☐ 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.

☐ 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 : D D / M M / Y Y Y Y

To : D D / M M / Y Y Y Y

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.

COMPASSIONATE VISIT

The person hospitalized : The Insured The Insured's Parent / Spouse / Child

Name of the person hospitalized (if not 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 : D D / M M / Y Y Y Y

Nature of treatment :

Date of hospitalisation : D D / M M / Y Y Y Y

Treating Doctor's opinion on how many more days the patient will need to be hospitalised :

Treating Doctor's opinion on why the insured cannot be sent back to India for further treatment: (Only applicable if the insured is hospitalised)

Treating Doctor's opinion on the need for an attendant :

Please attach a medical reports and certificate from the doctor confirming the above. Please attach more sheets to give details, if necessary.
Please attach **Doctors statement specifically stating the need for an attendant.**

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 : D D / M M / Y Y Y Y

Nature of treatment :

Dates of hospitalisation: From : D D / M M / Y Y Y Y To : D D / M M / Y Y Y Y

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 : D D / M M / Y Y Y Y To : D D / M M / Y Y Y Y

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.

For any claim related to / on account of accident or personal liability

Please describe the incident :

Date of Injury : / /

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

Attorney Name : Law Firm Name :

Phone : Address :

Please check the box below that best describes your injury :

Vehicular Accident

Type of Vehicle :

Single Vehicle Accident MultipleVehicle Accident

Vehicle Insurance Information for patient :

Driver Name :

Policyholder Name :

Insurance Co. Name :

Address :

Adjuster's Name :

Adjuster's Phone :

Claim Number :

Did you rent a car ? Yes 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 :

Policy holder Name :

Insurance Co. Name :

Premises Injury

Homeowner or Business Name :

Address :

Phone :

Insurance Co. Name :

Address :

Adjuster's Name :

Adjuster's Phone :

Claim Number :

Product Injury

Product Name :

Company Name :

Insurance Co. Name :

Address :

Adjuster's Name :

Address :

Adjuster's Name :

Adjuster's Phone :

Claim Number :

Adjuster's Phone :

Claim Number :

Other Injury

Please describe (Attach separate sheet if necessary)

I/We hereby agree, affirm and declare that:

A. The statements/information given/stated by me/us in this claim form are true, correct and complete.

B. 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.

C. 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.

D. 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.

E. 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.

F. 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 : D D / M M / Y Y Y Y

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 29, 30, 50

Direct Fund Transfer/EFT Mandate Form

A) Would you like to opt for Electronic Fund Transfer as mode of payment ? A) Yes ☐ B) No ☐

B) If yes, kindly provide the below mentioned details :

- Payee Name (as per bank records):
- Payee Account No.:
- Type of Account: ☐ Savings ☐ Current ☐ Others (specify):
- Name of the Bank :
- Branch Name :
- Address of the Bank :
- IFSC Code No. of the Bank:
- MICR Code No. of the Bank:
- Permanent Account Number (PAN) of Payee :

1) Please attach an **Original Blank Cancelled Cheque** signed by the Payee.	**Mandatory** ☐
2) Please attach a **PAN Card** copy of Payee	**Mandatory** ☐

Terms and Conditions for Payments through RTGS / NEFT

1. The details provided by the Customers in the Mandate Form shall be considered as final and ICICI Lombard General Insurance Company Ltd. shall not be responsible for cross verification of any of the details provided therein.
2. The RTGS / NEFT facility shall be effective for the respective Customer(s) within 15 days of the receipt of the Mandate Form by ICICI Lombard General Insurance Company Ltd. and/ or within such period as may be reasonably required by ICICI Lombard General Insurance Company Ltd. to activate the RTGS/ NEFT facility.
3. The Customer agrees that under the RTGS/ NEFT facility, there may be a risk of non-payment in the Account of Customer on the day of the credit of Payments due to change in the applicable regulations pertaining to RTGS/ NEFT facility or due to any other reasons without any fault/inaction/failure on part of ICICI Lombard General Insurance Company or any factor beyond the control of ICICI Lombard General Insurance Company Limited.
4. The Customer agrees to indemnify, without delay or demur, ICICI Lombard General Insurance Company Ltd. and its agents and keep ICICI Lombard General Insurance Company Ltd. and its agent indemnified harmless at all times from and against any and all claims, damages, losses, costs, and expenses (including attorney's fees) which ICICI Lombard General Insurance Company Ltd. may suffer or incur, directly or indirectly, arising from or in connection with, amongst other things, either of the aforesaid reasons stated in above clauses.
5. ICICI Lombard General Insurance Company Ltd. may sub-contract and employ agents to carry out any of its obligations under the RTGS/ NEFT facility. The Customer may discontinue or terminate the use of RTGS / NEFT facility by giving a minimum of 15 days prior written notice to ICICI Lombard General Insurance Company Ltd.The date of notice for ICICI Lombard will be the date of receipt of such notice by ICICI Lombard. The notice of such termination should be given to ICICI Lombard only at its corporate address and be addressed at ICICI Lombard GIC Ltd, ICICI Lombard House (Old Tata Press Building), 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai - 400025
6. A confirmation of the receipt of termination notice given by the Customer will be acknowledged through a confirmation letter by ICICI Lombard General Insurance Company Ltd. In no case can the Customer construe his termination notice as effective unless a confirmation has been provided by ICICI Lombard to the Customer stating the date of receipt of such communication by the Customer.
7. The Customer agrees that transaction(s) through RTGS/ NEFT facility may attract inward RTGS/ NEFT charges, which if levied by the Customer's bank, shall be borne by the Customer
8. ICICI Lombard has the absolute discretion to amend or supplement any Terms and Conditions stated herein at any time and will endeavor to give prior notice of Ten days for such changes wherever feasible for the terms and conditions to be applicable. By using the new services, or at the completion of such period, whichever is earlier, the Customer shall be deemed to have accepted the changed terms and conditions.
9. Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company.
10. Notices under these terms and conditions may be given in writing by delivering them by hand or e-mail or on ICICI Lombard General Insurance Company Ltd. website www.icicilombard.com or by sending them by post to the last address of the Customer.
11. These terms and conditions will be governed by the laws of India and any legal action or proceedings arising out of these Terms and Conditions shall be initiated in the courts or tribunals at Mumbai in India.
12. I / We further undertake to refund any excess amount whether demanded by ICICI Lombard General Insurance Company Ltd. or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from ICICI Lombard of such excess credit or such information of excess credit coming to the knowledge of the Customer through any other source.
13. I/ We agree that my/our claim payment will be credited from the date ICICI Lombard General Insurance Company Ltd. gets confirmation from its bankers, This facility will continue unless it is revoked by any party and any issuance of relevant credit instruction from ICICI Lombard General Insurance Company Ltd. to its bankers will be valid till such instruction is complete irrespective of the fact that the notice period has expired provided such a credit request has been made by ICICI Lombard General Insurance Company Ltd. before the expiry of the notice period of the Customer.

Signature of the Account Holder

ICICI Lombard
Aapka Plan B

Mailing Address : ICICI Lombard General Insurance Company Limited Interface Building No.11, 401/402 4th Floor, New Link Road Malad (W), Mumbai - 400064.
Corporate 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 **ihealthcare@icicilombard.com**
Now One Number for all your Insurance needs **1800 2666 (Toll Free also accessible from your mobile)**

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