CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED

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General Insurance

CHOLA MS Corporate Travel - Claim Form

• The issuance of this form is not to be taken as an Admission of Liability. • Please answer all questions completely. Use additional sheet, if required. • Please attach the document required as indicated. • Please note that the list of documents mentioned is an indicative list; the Insurer may ask for any other documents to process the claim. • Please attach the medical report in the enclosed format for claim under Personal Accident.

Details of The claimant:	Name of Claimant (in full)	Mr. Mrs.	Ms. Dr. Pr	of. M/s.	
Policy Number		Period of Insur	rance DDMM2000	Y To DDMM2000Y	
Address					
City	State			Pin code	
Telephone Number		Mobile Number			
Occupation		E-mail			
Relationship of claimant with the insured DD Date of commencement of Trip DD MM 2007 Date of Scheduled Return DD MM 2007					
Section to which Claim pertains (Please tick whichever is applicable)					
Medical Expenses (Medical Evacuation Inclu	uded)	Repatriation of Ren	nains (Within overall medic	cal limit)	
Dental Treatment Expenses	Total Loss of Checked Baggage	Delay of Checked-I	n Baggage	Loss of Passport	
Loss of International Driving License	Personal Accident – Overseas	Personal Liability		Financial Emergency	
Hospital Daily cash	Hijack Relief	Trip Cancellation	1 1	Trip Curtailment	
Trip delay	Emergency Travel Expenses - Repla	acement of Colleague Abroad			
Emergency Medical Expenses - Domestic (A	Accidental Hospitalization only within	India from residence to Airpor	rt and/or vice versa)		
Personal Accident - Domestic					
1. Medical Expenses - Please attach	Doctor's reports, Original admission /	discharge card, Original bills	/ receipts / with prescription	ons and diagnostic /investigative	
reports, Copy of passport / visa with entry	& exit stamp and copy of the ticket a	nd boarding pass.			
Name of the disease contacted			-		
	MM200Y Date when treatme			ended DDMM2000Y	
Date of admission	MM200Y Date of discharge	DDMM200	<u>3 Y </u>		
Name of Treating Doctor		Name of Clinic / Hospital			
Address					
Contact number	Nature of Disease/Injury (Ple	ase describe briefly)			
Hospital expenses (Please show each head	separately: Please mention in US Do	llars)			
a. Room rent	_ Consultancy Charges	,	Cost of treatment		
	, -				
Other costs	Outpatient expenses		Total Claim Amount		
2. Repatriation of Remains - if you expenses, please provide following details	are claiming for the extra costs of tra	ansportation home (for self an	d / or accompanying perso	on), mortal remains or burial	
a. Name of airlines		Burial Details			
Expenses incurred	Other incidental costs with I	oifurcation of expenses			
3. Dental Treatment Expenses - Pl	ease attach Doctor's reports. Original	admission / discharge card. C	Priginal hills / receints / wit	th prescriptions and diagnostic /	
investigative reports, Copy of passport / vi				, , , , , , , , , , , , , , , , , , , ,	
Name of the disease contacted					
When disease first manifested (Date)	MM200Y Date when treatme	nt started DDMM20	0 Y Date when treatment	ended DDMM2000Y	
Date of admission	M M 2 0 0 Y Date of discharge	D D M M 2 0 0	0 Y		
Name of Treating Doctor		Name of Clinic / Hospital			
Address					
Contact number	Nature of Disease/Injury (<i>Ple</i>	ase describe briefly)			
Hospital expenses (Please show each head	separately; Please mention in US Do	llars)			
Room rent	Consultancy Charges		Cost of treatment		
Other costs	Outpatient expenses		Total Claim Amount		

4. Total Loss of Checked-In Baggage – Please attach the details of individual items lost, approximate cost and purchase date, Copies of baggage tags, Copies of correspondence with airline authorities / others about loss of checked baggage, along with details of compensation received from airlines / other authorities (if any), Property Irregularity Report (obtained from airline), Copy of the passport / visa with entry & exit stamp, Adequate proof of ownership of items contained within checked-in-baggage valued in excess of the Indian rupee equivalent of US \$ 100 for loss/delay of checked-in-baggage will need to be submitted.

Number of Checked – In Baggage	
Nature and description of the items lost	
Description of the items lost with regards to number, nature and $% \left(1\right) =\left(1\right) \left(1\right) \left($	cost of each item
airline authorities certifying the delay, along with details of comp airline), Original bills / receipts / invoices connected to expenses	ails of items purchased during the delay period, Copies of baggage tags, Copies of correspondence with ensation received from airlines / other authorities (if any), Property Irregularity Report (obtained from incurred / purchases made during the delay period, Copy of the passport / visa with entry & exit stamp. Flight Number
From To Scheduled Departure Date and time	Scheduled Arrival Date and time
Actual Departure Date and time Description of items purchased with regards to number, nature and	Actual Arrival Date and time cost of each item
Total Claim Amount	
•	opy of previous passport (if available), Original bills / invoices of expenses incurred for obtaining a new
passport, Copy of FIR / police report.	••
Date of Loss Application Document F Incidental Cost Total Claim Amount _	ee
7. Loss of International Driving License – Please attact Original bills / invoices of expenses incurred for obtaining a new Date of Loss Application Document F Incidental Cost Total Claim Amount	ee
	report, Post Mortem Report, Death certificate, Medical report in the enclosed format, Certificate from
treating Doctor for Permanent Disability. Date and time of Accident $\begin{array}{c c} D & D & M & M & 2 & 0 & 0 & Y \end{array} \text{Full}$	description of the cause of accident
	Name of Clinic / Hospital
Address	
9. Personal Liability – Please attach the Judgment of the C	Total claim amount
Date and time of Accident DDMM200Y Nat	ure of Claim being made
Court where the case is being pursued	Total claim amount
10. Financial Emergency - Please attach the Police report	
Date and time of Loss DDMM200Y Place	
Amount of the fund lost	Total claim amount
	Total claim amount
12. Hijack Relief - Please attach the copy of passport / visa v	with entry & exit stamp (if any), copy of the ticket and boarding pass, the police report with details such
as the passport number of the Insured & period of hijacking, new	rspaper report (if available) Number To From To To
Scheduled Departure Date and time	Scheduled Arrival Date and time
Date and time of HijackFull description of the incident	Date and time of return
13. Trip Cancellation - Please attach the details of expense with airline authorities, hotel, car rental and tour operator certifyir Copy of ticket & boarding pass (if any), Copy of the passport / vi	is incurred, Original bills of expenses incurred due to cancellation, Copies of cancellation correspondence ing the cancellation, along with details of compensation received from airlines / other authorities (if any), sa with entry & exit stamp (if any), Proof of the reason for cancellation like Death certificate etc.
Scheduled Departure Date and time	Reason for Trip Cancellation
Total Claim Amount Please attach the details of expenses i	ncurred, Original bills of expenses incurred due to cancellation, Copies of cancellation correspondence
with airline authorities, hotel, car rental and tour operator certifyin Copy of ticket & boarding pass (if any), Copy of the passport / vi	ng the cancellation, along with details of compensation received from airlines / other authorities (if any), sa with entry & exit stamp (if any), Proof of the reason for cancellation like Death certificate etc. Number From To
Scheduled Departure Date and time	Reason for Trip Curtailment
	uring the delay period, Original bills of purchases made / expenses incurred during the period of delay,
O beauding once Convertible agency (vice with eather O switches	Number From To
Scheduled Departure Date and timeActual Departure Date and time	Scheduled Arrival Date and time Actual Arrival Date and time
Description of items purchased with regards to number, nature and	cost of each item
Total Claim Amount	Le Abroad - Please attach the details of expenses incurred, Copy of ticket & boarding pass (if any), Copy
of the passport / visa with entry & exit stamp (if any), Proof of the	ne reason for replacement like Name & Certificate Number of the Employee Hospitalised etc.
Name of airline To	Flight Number
Scheduled Departure Date and time	iting the reason for Replacement
17. Emergency Medical Expenses - Domestic (Accidental	Hospitalization only within India from Residence to Airport and/ or vice versa) Please attach
Doctor's reports, Original admission / discharge card, Original bill & exit stamp and copy of the ticket and boarding pass (as applications)	s / receipts / with prescriptions and diagnostic /investigative reports, Copy of passport / visa with entry
Date and time of Accident	Full description of the cause of accident
Date when treatment started	Date when treatment ended
Name of Treating Doctor	Name of Clinic / Hospital
Address Contact number	Nature of Injury
Hospital expenses (Please show each head separately)	• •
a. Room rent Cost of treatment	Consultancy Charges Other costs
Outpatient expenses	Total Claim Amount
	t, Post Mortem Report, Death certificate, Medical report in the enclosed format, Certificate from treating
Doctor for Permanent Disability. Date and time of Accident Full description of the cause of accident	Police report lodged - Yes/No
Name of Treating Doctor	Name of Clinic / Hospital
Address	·
Contact number	Total claim amount

Declaration

I/We hereby to the best of my/our knowledge and belief, warrant the truth of the above details in every respect. I/We agree that if we have made already or if I/We make in any of my/our further statements in respect of the said incident or any false or fraudulent declarations or suppress or conceal any material fact, the Policy shall be void and all rights of compensation in respect the present or future claim shall be forfeited.

Place: Date: