Cholamandalam MS
General Insurance

Claim Form - Overseas Student Travel Insurance

(The issuance of this Form does not imply admission of liability)

- 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

A. Details of The claimant: Name of Claimant *(in full)* Mr. Mrs. Ms. Dr. Prof. M/s.

Policy Number Period of Insurance D D M M 2 0 0 Y To D D M M 2 0 0 Y

Address

City State Pin Code

Telephone Number Mobile Number

Educational Institute E-mail

a. Name of the Institute. _____ b. Name of the course _____ c. Duration Of the course _____

Relationship of claimant with the insured Date of commencement of Trip D D M M 2 0 0 Y Date of Scheduled Return D D M M 2 0 0 Y

Section to which Claim pertains (Please tick whichever is applicable)

Medical Expenses ☐	Repatriation of Remains ☐	Dental Treatment Expenses ☐	Total Loss of Checked Baggage ☐
Bail Bond ☐	Study Interruption ☐	Sponsor Protection ☐	Compassionate Visit ☐
Personal Accident – Overseas ☐		Personal Liability ☐	Personal Accident – Domestic ☐

B. Medical Expenses – Please attach Doctor's reports, Original admission / discharge card, Original bills / receipts / with prescriptions and diagnostic /investigative reports, Copy of passport / visa with entry & exit stamp and copy of the ticket and boarding pass.

Name of the disease contracted

When disease first manifested (Date) D D M M 2 0 0 Y Date when treatment started D D M M 2 0 0 Y Date when treatment ended D D M M 2 0 0 Y

Date of admission D D M M 2 0 0 Y Date of discharge D D M M 2 0 0 Y

Name of Treating Doctor Name of Clinic / Hospital

Address

Contact number Nature of Disease/Injury *(Please describe briefly)* _____

Hospital expenses *(Please show each head separately; Please mention in US Dollars)*

Room rent ..... Consultancy Charges ..... Cost of treatment .....

Other costs ..... Outpatient expenses ..... Total Claim Amount .....

Transportation Expenses – if you are claiming for the extra costs of transportation home (for self and / or accompanying person), mortal remains or burial expenses, please provide following details

Name of airlines ..... Burial Details .....

Expenses incurred ..... Other incidental costs with bifurcation of expenses .....

C. Dental Treatment Expenses - Please attach Doctor's reports, Original admission / discharge card, Original bills / receipts / with prescriptions and diagnostic /investigative reports, Copy of passport / visa with entry & exit stamp and copy of the ticket and boarding pass.

Name of the disease contacted

When disease first manifested (Date) D D M M 2 0 0 Y Date when treatment started D D M M 2 0 0 Y Date when treatment ended D D M M 2 0 0 Y

Date of admission D D M M 2 0 0 Y Date of discharge D D M M 2 0 0 Y

Name of Treating Doctor Name of Clinic / Hospital

Address

Contact number Nature of Disease/Injury *(Please describe briefly)* _____

Hospital expenses *(Please show each head separately; Please mention in US Dollars)*

Room rent ..... Consultancy Charges ..... Cost of treatment .....

Other costs ..... Outpatient expenses ..... Total Claim Amount .....

D. Loss of Passport - Please attach Copy of new passport, Copy of previous passport (if available), Original bills / invoices of expenses incurred for obtaining a new passport, Copy of FIR / police report.

Date of Loss D D M M 2 0 0 Y Application Document fees _____ Incidental Cost _____ Total Claim Amount _____

E. 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 cost of each such item ..... Total claim amount - - - - - - - -

Name of the Airline

Flight No. _____ From _____ To _____

Scheduled Departure Date D D M M 2 0 0 Y Time Hrs Scheduled Arrival Date D D M M 2 0 0 Y Time Hrs

Actual Departure Date D D M M 2 0 0 Y Time Hrs Actual Arrival Date D D M M 2 0 0 Y Time Hrs

Description of items purchased with regards to number, nature and cost of each such item _____ Total claim amount _____

F. Bail Bond

a. Date and Time _____ b. Name of the Lawyer _____

Details to be attached: 1. Copy of arrest warrant. 2. Proof/Details about the offence 3. Order of court

G. Study Interruption - Please attach following documents

- On account of death of the Insured's Immediate Family Member - Medical reports, Statements from treating doctor, Death certificate with a physician's statement giving the cause of death. Medical statements from relations or spouses will not be accepted.
- If in case of hospitalisation of insured - Medical reports, statement from physician indicating necessarily for it needs to be submitted.

a. Name of the Patient. _____ b. Relationship with Insured_____

c. Details of illness/accident._____ d. Date & Time. _____

H. Sponsor Protection

- An official death certificate ▪ A physician's statement giving the cause of death. ▪ All relevant medical reports ▪ Police report lodged
- Name of Sponser. _____ . Relationship. _____

I. Compassionate Visit

- Medical reports and certificates from the doctor confirming the necessacity for the same needs to be submitted.
- Name of the Patient._____ . Relationship with Insured ._____
- Details of illness/accident._____ . Date & Time ._____
- Details of Journey (Flight Details etc.,)_____

J. Personal Accident – Overseas Please attach Police report, Port 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 .....

Name of Treating Doctor ..... Name of Clinic / Hospital .....

Address .....

Contact number ..... Total claim amount .....

K. Personal Liability – Please attach the Judgment of the Court

Date and time of Accident .....

Nature of Claim being made .....

Court where the case is being pursued .....

Total amount of the award including claimant amount ..... Total claim amount .....

L. Personal Accident – Domestic Travel Please attach Police report, Port Mortem Report, Death certificate, Medical report in the enclosed format**,** Certificate from treating Doctor for Permanent Disability.

Date and time of Accident .....

Police report lodged Yes/No ..... Full description of the cause of accident .....

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: **Signature of Claimant/Insured**

MEDICAL REPORT

(To be filled by treating Doctor)

1. Name of the Injured Person: .....
2. Are you his/her usual medical attendant? Yes ..... No .....
3. Details of Injuries sustained: .....
4. Cause of Injuries sustained: .....
5. Does nature of injury sustained corresponds to the cause? Yes ..... No ..... if No, provide details .....
6. Are the injuries suffered solely due to accident? Yes ..... No ..... if No, provide details .....
7. Was the injured person under influence of Liquor/drugs at the time of accident? Yes ..... No .....
8. What was the treatment administered? .....
9. How many days was the injured person in hospital? .....
10. Details & dates of treatment
    Date and time of admission in the Hospital: .....
    Date and time of discharge from the Hospital: .....
    Home From: ..... To: .....
11. Nature of injury suffered with the insured/injured person
    Fatal ..... PTD ..... PPD ..... TTD .....
12. Incase of PTD/PPD – kindly state the % of disability .....
13. in you opinion when will the insured/injured person will be able to resume duties? .....

I hereby to the best of my knowledge and belief, warrant the truth of the above details in every respect.

Place: ..... *Date:* ..... *Signature and Stamp* .....

Name of Doctor: ..... *Registration No.:* .....

Address.: .....