

**TATA-AIG GENERAL INSURANCE COMPANY LIMITED**

AHURA CENTER, 4TH FLOOR,  
MAHAKALI CAVES ROAD,  
ANDHERI (E), MUMBAI - 400 093



**OVERSEAS TRAVEL INSURANCE CLAIM FORM**

**IMPORTANT:**

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

**For the Americas Policies:** 1-866-866-2619 (Toll Free) / Direct Dial - 713-260-5519

Email: [tata.aig@aig.com](mailto:tata.aig@aig.com).

**For rest of the world policies excluding the Americas:** Ph : 0091-11-41898860 / Fax : 0091 - 11 - 41898801

Email: [delhi.tata-aig@internationalalsos.com](mailto:delhi.tata-aig@internationalalsos.com)

**Failure to call our Assistance Company on 24-hour helpline, in respect of Medical Accident & Sickness Claims shall invalidate your claim, if any. Please note, the first US\$100 of your medical expenses is deductible, and must be borne by you.**

1. This is a One Call Claim Form, except for Accidental Death & Dismemberment (ADD). For ADD, we shall provide a separate Claim Form upon notification.
2. Issuance of the form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract.
3. No claim under Accident & Sickness Section will be admitted without Doctor's Report as per format (Attending Doctor's Report - Page 3)
4. Please answer all questions completely. In case of insufficient space, please attach an additional sheet.
5. Please attach all Original bills & receipts pertaining to your claim.

Certificate/ Policy No. \_\_\_\_\_ Period From \_\_\_\_\_ to: \_\_\_\_\_

**DETAILS OF PATIENT/ INSURED PERSON**

Name : \_\_\_\_\_ Phone Nos. \_\_\_\_\_

Permanent Address (INDIA): \_\_\_\_\_

Email Id : \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex: M / F

Assistance Company Ref No.: \_\_\_\_\_

Passport No.: \_\_\_\_\_

Date of Departure: \_\_\_\_/\_\_\_\_/\_\_\_\_

Flight No. \_\_\_\_\_

From \_\_\_\_\_ to \_\_\_\_\_

Date of Arrival: \_\_\_\_/\_\_\_\_/\_\_\_\_

Flight No. \_\_\_\_\_

From \_\_\_\_\_ to \_\_\_\_\_

Please indicate whether claim is in respect of: Accident & Sickness ☐ Travel Delay ☐ Baggage Loss ☐

Baggage Delay ☐ Loss of Passport ☐

**\*Please complete the Section relevant to your claim.**

**LOSS/DELAY OF CHECKED BAGGAGE**

Describe when & where the loss/delay took place: \_\_\_\_\_

State the extent of Loss: \_\_\_\_\_

Name the common carrier: \_\_\_\_\_

1. Flight No. \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_

2. Flight No. \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_

Has the common carrier been notified at the time of loss? Yes ☐ No ☐ Airline Reference No. \_\_\_\_\_

Details of compensation received from carrier: \_\_\_\_\_

Scheduled date/time of Arrival: \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_ hrs. Actual date/time when bags delivered : \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_ hrs

No. of Hours delayed : \_\_\_\_\_

| Item Purchased/Lost *                    | Date of Purchase | Place | Cost |
|------------------------------------------|------------------|-------|------|
|                                          |                  |       |      |
|                                          |                  |       |      |
|                                          |                  | TOTAL |      |
| Less Compensation received from Airline: |                  |       |      |

**Net Amount:**

*\* In case of Delay, please provide details of purchases made*

*\* In case of Loss, please provide details of items lost.*

**LOSS OF PASSPORT**

Please provide details of the incident i.e. when, where and how it happened: \_\_\_\_\_

Details of Police Report (please attach copy): No: \_\_\_\_\_ Date: \_\_\_\_\_ Place: \_\_\_\_\_

| Details of Expense incurred |  | Date | Place | Amount |
|-----------------------------|--|------|-------|--------|
|                             |  |      |       |        |
|                             |  |      |       |        |
|                             |  |      | TOTAL |        |

| TRAVEL DELAY                                                                                                  |      |              |        |
|---------------------------------------------------------------------------------------------------------------|------|--------------|--------|
| Flight No. _____ Date ____/____/____ From _____ to _____                                                      |      |              |        |
| Scheduled time of Departure: _____ Actual time of Departure: _____ No. of Hours delayed: _____                |      |              |        |
| Whether accomodation & boarding provided by carrier: Yes <input type="checkbox"/> No <input type="checkbox"/> |      |              |        |
| Details of Expense incurred                                                                                   | Date | Place        | Amount |
|                                                                                                               |      |              |        |
|                                                                                                               |      |              |        |
|                                                                                                               |      | <b>TOTAL</b> |        |

| MEDICAL ACCIDENT & SICKNESS BENEFIT                                                                                      |                 |    |                    |                   |                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------|-----------------|----|--------------------|-------------------|---------------------------------------------------------|--|
| If accident, details of accident i.e. how, when, where it took place: _____                                              |                 |    |                    |                   |                                                         |  |
| Date: _____ Place: _____                                                                                                 |                 |    |                    |                   |                                                         |  |
| If sickness, state nature and diagnosis, and advise when & where symptoms first occurred: _____                          |                 |    |                    |                   |                                                         |  |
| Date: _____ Place: _____                                                                                                 |                 |    |                    |                   |                                                         |  |
| Name & Address of consulting physician: _____                                                                            |                 |    |                    |                   |                                                         |  |
| Have you ever been treated for this illness before: <input type="checkbox"/> Yes <input type="checkbox"/> No             |                 |    |                    |                   |                                                         |  |
| If yes, provide name & address of consulted physician: _____                                                             |                 |    |                    |                   |                                                         |  |
| Provide name & address of your family physician: _____                                                                   |                 |    |                    |                   |                                                         |  |
| Provide name of any prescription medicine you are presently taking: _____                                                |                 |    |                    |                   |                                                         |  |
| Indicate other health insurance coverages, including name, address, policy number & certificate number of insurer: _____ |                 |    |                    |                   |                                                         |  |
| DETAILS OF MEDICAL EXPENSES                                                                                              |                 |    |                    |                   |                                                         |  |
| Details of treatment                                                                                                     | In/ Out Patient |    | Charges (Currency) | Status of Payment |                                                         |  |
|                                                                                                                          | From            | To | Eg : USD / EURO    | Paid/ Outstanding |                                                         |  |
|                                                                                                                          |                 |    |                    |                   |                                                         |  |
|                                                                                                                          |                 |    |                    |                   | <div>Paid</div> <div>Outstanding</div> <div>TOTAL</div> |  |
|                                                                                                                          |                 |    |                    |                   |                                                         |  |
|                                                                                                                          |                 |    |                    |                   |                                                         |  |
| Whether Assistance Co. was contacted: Yes No. If Yes, Reference No. _____                                                |                 |    |                    |                   |                                                         |  |
| If No, give reasons: _____                                                                                               |                 |    |                    |                   |                                                         |  |

| AUTHORIZATION                                                                                                                                                                                                                                                                                                                                                                                                                        |              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|
| 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: _____ |
| Signature of insured : _____                                                                                                                                                                                                                                                                                                                                                                                                         |              |

| Attending Doctor's Report                                                                                                                                                                   |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| Patient's Name: _____ Age: _____ Sex: _____ M / F                                                                                                                                           |  |  |  |
| Address: _____                                                                                                                                                                              |  |  |  |
| _____                                                                                                                                                                                       |  |  |  |
| Date contacted: _____ Time: _____                                                                                                                                                           |  |  |  |
| For Accidental Injury                                                                                                                                                                       |  |  |  |
| Nature of Injury: _____                                                                                                                                                                     |  |  |  |
| _____                                                                                                                                                                                       |  |  |  |
| X-Ray Taken: <input type="checkbox"/> s      No <input type="checkbox"/> Date taken: _____                                                                                                  |  |  |  |
| Diagnosis and Treatment Given: _____                                                                                                                                                        |  |  |  |
| _____                                                                                                                                                                                       |  |  |  |
| _____                                                                                                                                                                                       |  |  |  |
| Describe any other disease or infirmity affecting present condition: _____                                                                                                                  |  |  |  |
| For Sickness                                                                                                                                                                                |  |  |  |
| Nature of Illness: _____                                                                                                                                                                    |  |  |  |
| _____                                                                                                                                                                                       |  |  |  |
| _____                                                                                                                                                                                       |  |  |  |
| Diagnosis and Treatment Given: _____                                                                                                                                                        |  |  |  |
| _____                                                                                                                                                                                       |  |  |  |
| _____                                                                                                                                                                                       |  |  |  |
| When did patient's symptoms first appear: _____                                                                                                                                             |  |  |  |
| Describe any other disease or infirmity affecting present condition: _____                                                                                                                  |  |  |  |
| _____                                                                                                                                                                                       |  |  |  |
| Is condition due to Pregnancy: Yes <input type="checkbox"/> No <input type="checkbox"/> Is illness due to any pre-existing condition: Yes <input type="checkbox"/> <input type="checkbox"/> |  |  |  |
| Signature: _____                                                                                                                                                                            |  |  |  |
| Attending Doctor's Signature                                                                                                                                                                |  |  |  |