THE ORIENTAL INSURANCE COMPANY LIMITED

Regd. Office : ORIENTAL HOUSE, P. B. No. 7037, A-25/27 Asaf Ali Road. New Delhi–110 002

CLAIM FORM FOR OVERSEAS MEDICLAIM POLICY

(To be submitted to below mentioned address for lodging claim)

CORIS INTERNATIONAL

RUE AUBER, 75009, PARIS, FRANCE

Name of Person Claiming : Mr. / Mrs.
Home Address in India :

Occupation: Day : _____ Time : _____ Tel No. : _____

DETAILS OF POLICY	C.O. CODE	OFFICE CODE	PLAN	CATEGORY	SERIAL NO
Policy Number					

Date – Policy Issued:

Date – Trip Commenced :

No. of Days :

Scheduled Date of Return:

Geographical Limits	Worldwide Excl. USA / CANADA	Worldwide Incl. USA / CANADA

NAME AND AGE OF EACH PERSON INCLUDED IN THE CLAIM

Mr. / Mrs. / Miss.	Initials	Surname	Date of Birth ____ / ____ / _____ DD MM YY

POLICY SECTION RELATING TO CLAIM (Tick Boxes)

- Medical Expenses ☐
- Personal Accident ☐
- Loss of Checked in Baggage ☐
- Delay of Checked in Baggage ☐
- Loss of Passport ☐
- Personal Liability ☐

DATE OF CLAIM OCCURANCE: TRIP DESTINATION:

PLEASE COMPLETE APPROPRIATE SECTION OF CLAIM FORM AND READ CAREFULLY THE INSTRUCTIONS RELATING TO SUPPORTING DOCUMENTS REQUIRED. WHEN COMPLETED PLEASE SIGN DECLARATION :
I Declare that to the best of my knowledge all particulars contained in this form are true. I also authorize Coris to obtain my medical records or information necessary to process the claim.

Signed: Date: Place:

MEDICAL AND EMERGENCY EXPENSES / HOSPITAL BENEFIT / PERSONAL ACCIDENT (INCLUDING ADDITIONAL TRAVEL, ACCOMODATION EXPENSE)

I) DOCUMENTS REQUIRED :

The following documents must be enclosed with your completed claim form :

- ORIGINAL CERTIFICATE OF INSURANCE TOGETHER WITH ANY COPIES OF AIRLINE TICKET
- ORIGINAL BILLS OR RECEIPTS FOR FULL AMOUNT OF CLAIM (PHOTOCOPIES NOT ACCEPTABLE)
- CONFIRMATION BY HOSPITAL OF DATES OF HOSPITALISATION (FOR CLAIMS FOR HOSPITAL BENEFITS)
- DEAT H CERTIFICATE (FOR COMPENSATION CLAIM OF DEATH BY ACCIDENT)
- DISABLEMENT CERTIFICATE AND POLICE REPORT (FOR PERSONAL ACCIDENT CLAIM)
- THE MEDICAL CERTIFICATE DOES NOT NEED TO BE COMPLETED FOR MINOR ACCIDENTS OR ILLNESS
- PHYSICIAN'S REPORT (ORIGINAL ATTACHED TO THE POLICY IF APPILCABLE)

These documents must be supplied with the completed claim form at the Claimant's expense. Failure to do so will delay the processing of your claim and could result in it being declined.

II) TO BE COMPLETED BY THE CLAIMANT OR THE CLAIMANT'S LEGAL REPRESENTATIVE :

1. Name of Sick or Injured Person :
2. Nature of Injury / Illness :
3. Date of Injury / Illness :
4. Place of Injury / Illness :
5. Circumstances of Injury :
6. If claim was due to hospitalization or confinement, was the Emergency Assistance Department contacted YES / NO. If no, please advise why, on an additional information sheet.
7. Dates of Hospitalization : From - To –
8. Details of Claim :
9. Details of any third parties involved in accidental injury or death of insured person.
10. Details of Private Health Insurance
    a) Name of Insurer :
    b) Address of Insurer :
    c) Policy Number :
    d) Telephone Number :

Details of Claimed Expenses, Providers Name, Prescription Charges, etc.	**Amount Charged in Local Currency**	**IMPORTANT Has Bill Been Paid By You***
		YES / NO YES / NO
		YES / NO
		YES / NO YES / NO
		YES / NO
TOTAL AMOUNT		YES / NO *Delete where Applicable

LOSS OF CHECKED IN BAGGAGE,
BAGGAGE DELAY ON OUTBOUND FLIGHTS

I) DOCUMENTS REQUIRED :

- ORIGINAL CERTIFICATE OF INSURANCE (PHOTOCOPIES NOT ACCEPTED UNLESS IT IS AN ANNUAL POLICY)
- AIRLINE TICKETS
- ANY AVAILABLE RECEIPTS FOR THE LOST BAGGAGE. IF UNAVAILABLE SUPPLY ANY OTHER DOCUMENTATION WHICH COULD ASSIST IN GIVING PROOF OF VALUE, eg. VALUATIONS, SALES LITERATURE, ETC.
- ORIGINAL OF ALL WRITTEN REPORTS RECEIVED FROM CARRIER. IF VERBAL REPORT ONLY WAS MADE PLEASE SPECIFY
- PLEASE SUPPLY PROPERTY IRREGULARITY REPORT AND COPIES OF YOUR CORRESPONDENCE WITH THE AIRLINE
- IF CLAIM IS FOR DELAYED BAGGAGE, PLEASE SUPPLY PROPOERY IRREGUALRITY REPORT AND LETTER FROM CARRIER CONFIRMING REASON FOR DELAY AND DURATION OF THE DELAY.

THESE DOCUMENTS MUST BE SUPPLIED WITH THE COMPLETED CLAIM FORM AT THE CLAIMANT'S EXPENSES, FAILURE TO DO SO WILL DELAY THE PROCESSING OF YOUR CLAIM AND COULD RESULT IN IT BEING DECLINED.

II) TO BE COMPLETED BY THE CLAIMANT OR THE CLAIMANT'S LEGAL PERSONAL R EPRESENTATIVE.

1) T ime, Date and Place of Loss / Delay :

2) Full Circumstances of Loss / Delay :

3) Loss / Delay occurred in the custody of an airline.

   a) Date reported to Carrier :

   b) Name and address of Carrier :

4) Name and Position of any other person in authority to whom the matter was reported.

5) Details of Household Contents or All Risks Policy or any other Policy in force which may cover this loss including Private Travel Extension (THIS SECTION MUST NOT BE LEFT BLANK)

   Name of Insurer :

   Address :

   Policy No. :

   Tel. No. :

LOSS OF PASSPORT

I) DOCUMENTS REQUIRED :

- ORIGINAL CERTIFICATE OF INSURANCE (PHOTOCOPIES NOT ACCEPTED UNLESS IT IS AN ANNUAL POLICY)
- AIRLINE TICKETS
- POLICE REPORT
- BILLS AND OTHER SUPPORTING DOCUMENTS FOR OBTAINING EMERGENCY TRAVEL DOCUMENT WHILST ABROAD.

III) TO BE COMPLETED BY THE CLAIMANT OR THE CLAIMANT'S LEGAL PERSONAL R EPRESENTATIVE.

1) T ime, Date and Place of Loss :

2) Full Circumstances of Loss :

3) Name and Position of any other person in authority to whom the matter was reported.

ADDITIONAL INFORMATION YOU MAY WISH TO GIVE IN SUPPORT OF YOUR CLAIM UNDER ANY SECTION OF THE POLICY

SPECIAL SETTLEMENTS – U. S. A

Once a claim becomes payable under the terms and conditions of the policy and any costs have been met by you or any person on your behalf please indicate below to whom you would like the cheque be made payable to and their full address :

Payees Name :

Address :

When a medical incident has occurred in the USA with total bills not exceeding $500/- in all, the Insured may also post the policy schedule and this fully completed claim form together with the original medical invoices to Coris International, Coris International, 200, S. E. First Street, Suite 602, MIAMI, FL 33131., E-mail : corisusa@aol.com , Assistance Center : Tel : 1 305 372 0071 / 1 305 358 91 00 , Fax 1 305 371 6108 , Management, Administration and Claims, Tel. : 1 305 371 2961, Fax.: 1 305 371 5693. On receipt, Coris will immediately arrange payment either to the Insured or to the Medical Provider. If the claim cannot be paid for any reason (such as incomplete claim form or lack of documentation) or if the claim is for a greater amount than US$ 500/- then Coris will deal with it under the normal settlement procedures in the France.

Toll Free Nos. in U.S.A.

1) 1-877-536-7264 (Within U.S.A)
2) 305 – 358 –2102 (Within the State of Miami only)

In case of filing the claim on return to India, the above-referred documents may be posted to M/s. Heritage Health Services Pvt. Ltd., Unit 28, Ground Floor, T V Industrial Estate (Behind Glaxo), Hind Cycle Road, Worli, Mumbai – 400 025.

The payment of a claim in this manner does not prejudice the Insurer's right to decline further payments if the claim is subsequently found to be invalid.

TO BE SIGNED BY THE INSURED.

I wish my claim, which does not exceed US$ 500/- in all, to be dealt with under the above special arrangement.

SIGNATURE :