

Easy Travel Claim Form

Issuance of this form does not amount to admission of any liability or a waiver of any of the terms and conditions of the insurance contract. If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or any Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy shall be void and all benefits paid under it shall be forfeited.

Please give the following information correctly and completely to enable us to process Your claim promptly. Use additional sheets, if required. We may call for additional document/information as relevant.

A) Details of the Policy

Policy Number (in full) _____
 Certificate Number (for Group Policies) _____
 Policy Commencement Date (DDMMYYYY) _____ Policy Expiry Date (DDMMYYYY) _____
 Name of Policyholder _____
 Claim Reference provided during intimation _____

B) Details of the Insured Person

Name of the Insured Person _____
 Date of Birth (DDMMYYYY) _____ Gender: Male / Female
 Passport Number _____
 Permanent Address in India _____

 Residence Address abroad _____

 Occupation _____
 Relationship to the Policyholder & other Insured Person _____
 Telephone (in India) _____ Mobile (in India) _____
 Telephone (abroad) _____ Mobile (abroad) _____
 Email-ID _____

C) Details of the Claimant (if different than the Insured Person)

Name _____
 Date of Birth (DDMMYYYY) _____ Gender: Male / Female
 Passport Number _____
 Permanent Address _____

 Relationship to the Policyholder / Insured Person _____
 Telephone (in India) _____ Mobile (in India) _____
 Email-ID _____

D) Details of the Claim

Please tick the applicable benefit You want to claim for

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Medical Treatment | <input type="checkbox"/> Dental Treatment | <input type="checkbox"/> Medical Evacuation | <input type="checkbox"/> Repatriation of Mortal Remains |
| <input type="checkbox"/> Loss or Delay of Baggage | <input type="checkbox"/> Loss of Passport | <input type="checkbox"/> Financial Emergency Cash | <input type="checkbox"/> Personal Accident & Common carrier |
| <input type="checkbox"/> Personal Liability | <input type="checkbox"/> Hijack Daily Allowance | <input type="checkbox"/> Substitute Employee | <input type="checkbox"/> Emergency Travel and Hotel |
| <input type="checkbox"/> Trip Cancellation | <input type="checkbox"/> Trip Delay | <input type="checkbox"/> Trip Curtailment | <input type="checkbox"/> Missed Connection |
| <input type="checkbox"/> Hospital Daily Allowance | | | |

E) Medical Treatment / Dental Treatment / Hospital Daily Allowance

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

Name, Address and Contact Number of Treating Doctor / Physician / Dentist / Clinic or Hospital:

Name of the disease contracted _____
 When disease first manifested (Date) _____
 Dates of treatment: Start _____ End _____
 Date of admission _____ Date of discharge _____
 Nature of Disease/Injury (Please describe briefly) _____

If Accident, please provide details, i.e. how, when and where it took place.

Please enclose Police Report, if available.

Please provide the cost details for the Expenses (bills, invoices, prescriptions etc) in Section M of this claim form and mention the currency.

Please tick when You also claim for Hospital Daily Allowance.

F) Medical Evacuation / Repatriation of Mortal Remains

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

Name, Address and Contact Number of Treating Doctor/Physician/Dentist/Clinic or Hospital:

Name of the disease contracted _____
 When disease first manifested (Date) _____
 Dates of treatment: Start _____ End _____
 Date of admission _____ Date of discharge _____
 Nature of Disease/Injury (Please describe briefly) _____

Reason for Medical Evacuation _____

Date of Death (DDMMYYYY) _____
 Cause of Death _____

Please attach the official death certificate and a physician's statement for cause of death.

If Accident, please provide details, i.e. how, when and where it took place.

Please enclose Police Report, if available.

Please provide the cost details for the Expenses (bills, invoices, prescriptions etc) in Section M of this claim form and mention the currency. Also, please provide, if applicable, name of the airline, burial details with bifurcation of incurred Expenses.

G) Loss or Delay of Checked-in Baggage

Please attach the original invoice / receipts with the details of individual items purchased during the delay period / individual items lost, cost and purchase date, Copies of baggage tags, Copies of correspondence with airline authorities / others about loss / delay 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 and 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 of checked-in-baggage will need to be submitted.

Name of the Carrier _____
 Flight Number _____ From _____ To _____
 Scheduled Departure Date and time _____
 Scheduled Arrival Date and time _____
 Actual Departure Date and time _____
 Actual Arrival Date and time _____
 Date and Location of loss _____
 Date and time of Checked – In Baggage retrieval _____
 Number of Checked – In Baggage _____
 Description of the items lost with regards to number, nature and cost of each item _____

 Description of items purchased with regards to number, nature and cost of each item _____

 Total Claim Amount _____

H) Loss of Passport / Financial Emergency Cash

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 and time of Loss _____ Place of Loss _____
 Description of the circumstances of Loss _____

 Application Document Fee _____
 Incidental Cost _____
 Amount of the fund lost _____
 Total Claim Amount _____

I) Personal Liability / Personal Accident and Common Carrier

Please attach Police report, Post Mortem Report (incase of death) , official death certificate (incase of death), Medical report in the enclosed format, Certificate from treating Doctor for Permanent Disability, Original photograph of the injured reflecting disablement, Judgment of the Court for Personal Liability.

Date and time of Accident _____
 Place of Accident _____
 Full description of the cause of accident _____

 Name, Address and Contact Number of Treating Doctor / Physician / Dentist / Clinic or Hospital:

 Nature of Claim being made _____
 Court where the case is being pursued _____

J) Hijack Daily Allowance

Please attach Police report with details such as passport number and period of hijacking, Copy of the passport / visa with entry and exit stamp, newspaper reports / TV Clip or any other media coverage (if available).

Name of the Carrier _____
 Flight Number _____ From _____ To _____
 Scheduled Departure Date and time _____
 Scheduled Arrival Date and time _____
 Date and time of Hijack _____
 Actual Date and time of return _____
 Description of the incident _____

K) Trip Delay / Trip Cancellation and Curtailment / Missed Connection

Please attach any detailed report / confirmation from the carrier / Hospital / Police / others of incident which leads to the delay / cancellation / curtailment of the flight / trip, Copies of correspondence with airline authorities / others about delay / cancellation / curtailment, along with details of compensation received from airlines / other authorities (if any), Original admission / discharge card, diagnostic /investigative reports of hospitalisation, official death certificate, Copy of the passport / visa with entry and exit stamp.

Name of the Carrier _____
 Flight Number _____ From _____ To _____
 Scheduled Departure Date and time _____
 Scheduled Arrival Date and time _____
 Name of the Carrier _____
 Flight Number _____ From _____ To _____
 Actual Departure Date and time _____
 Actual Arrival Date and time _____
 Description of incident _____

Please provide the cost details for the Expenses (bills, invoices, prescriptions etc) in Section M) of this claim form and mention the currency.

L) Substitute Employee / Emergency Travel and Hotel

Please attach Doctor's reports, Original admission / discharge card, diagnostic /investigative reports, (Copy of passport / visa with entry and exit stamp and copy of the ticket and boarding pass for the Insured Person as well as Substitute employee), certificate from the employer establishing the official visit of both employees.

Name, Address and Contact Number of Treating Doctor / Physician / Dentist / Clinic or Hospital:

 Date of admission _____ Date of discharge _____
 Nature of Disease/Injury (Please describe briefly) _____

 Relationship to the other Insured Person _____

Please provide the cost details for the Expenses (bills, invoices etc) in Section M of this claim form and mention the currency.

M) Details of Expenses

No.	Expense Details	Issued by	Currency	Amount	Amount of received reimbursement	Remarks

N) Declaration

I, the undersigned, authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator furnish to Apollo DKV or its representatives, any and all information with respect to any injury or illness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, illness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I hereby warrant that:

- (1) I have read and understood the terms, conditions and exclusions of this Policy, and
- (2) that the foregoing particulars are true and complete in all material respects, and
- (3) there is no other insurance in force that may apply to this claim.

Date and Place _____

Signature _____

O) Medical Report (to be filled by Treating Doctor)

Patient's Name _____
Date of Birth (DDMMYYYY) _____ Gender: Male / Female
Patient's Address _____

Date and time of first consultation _____
Dates of treatment: Start _____ End _____
Date of admission _____ Date of discharge _____
Nature of complaints _____

Diagnosis _____
Treatment given _____

History of presented complaints _____

Is the present condition due to pregnancy? Yes No If yes, provide details _____

Is the present condition due to any pre-existing condition? Yes No If yes, provide details _____

Please provide history of any disease, accident or hospitalisation with details and duration _____

Date and time of the accident _____
Are the injuries suffered solely due to the accident? Yes No If no, provide details _____

Was the patient under influence of alcohol / drugs at the time of the accident? Yes No

Is the injured person totally disabled from each and every occupation? Yes No

Is the injured person partially disabled from occupation? Yes No If yes, please provide the percentage of disability _____

Prognosis of the ailment / injury _____

In your opinion when will the injured person 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 _____ Reg.No. _____

Name, address and stamp of Doctor _____

Signature _____

