Claim Form - 'Add-on-Explore Plus'

Please Note:

1) Please give the required information correctly and completely to enable us to process your claims promptly.
2) Use additional sheets, if required.
3) We may call for additional documents/ information as relevant.
4) The claim form should be supported by all the documents as specified in the Policy.
5) The issue of this form shall not to be taken or deemed to be taken as an admission of liability by the Company.

Section A - Details of the Policy

Add-on Policy number:

Insured name:

c) Certificate of Insurance number:

Base Policy number:

Section B - Details of Insured Person / Claimant

Name :

(Surname) (First Name) (Middle Name)

Address :

City :

State :

Pin Code :

Country :

Mobile :

E-mail :

Section C - Details of Claim

If a claim is made for any of the following Benefits kindly tick the appropriate Benefit and fill in the corresponding below details:-

Missed Carrier ☐ Trip Delay ☐ Missed Connection ☐

Name of Common Carrier :_____

Scheduled departure: Date (DDMMYYYY) Time (HHMM)

Scheduled arrival: Date (DDMMYYYY) Time (HHMM)

Common Carrier route: From: _____ To: _____

Name of Common Carrier :_____

Actual departure: Date (DDMMYYYY) Time (HHMM)

Actual arrival: Date (DDMMYYYY) Time (HHMM)

Common Carrier route: From: _____ To: _____

For Missed Connection only :-

Name of Connecting Common Carrier: _____

Connecting Common Carrier route: From: _____ To: _____

Scheduled departure: Date (DDMMYYYY) Time (HHMM)

Description of incident: _____ _____

Total expenses _____

For Missed Carrier only :-

Name of Road transport used : _____

Estimated Time of Arrival to departure point: Date (DDMMYYYY) Time (HHMM)

Actual Time of Arrival to departure point: Date (DDMMYYYY) Time (HHMM)

Ver JAN'22/AS

Description of incident: _____

Total expenses _____

Delay of Checked-in Baggage ☐

Name of Common Carrier_____

Date and time of arrival date: ☐☐☐☐☐☐☐☐ Time (HHMM): ☐☐☐☐

Port of disembarkation: _____

Date and time of baggage retrieval Date: Time (HHMM):

Serial no.	Expense details	Amount(Rs)

I/We hereby agree, affirm and declare that:

a. The information/statements given/ stated by me/us in this claim form are true, correct and complete.

b. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.

c. If I/we have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the Policy shall be void and that I/We shall not be entitled to all/any rights to recover there under in respect of any or all claims, past, present or future. The receipt of this claim form/other supporting/related documents does not constitute or deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further information and documents in respect of the claim.

d. I hereby authorize the physician or hospital or police authorities or governmental agency or any other institute to provide to Care Health Insurance Limited, or its offices or legal advisers or any investigative agency or their representative acting on its behalf, information regarding the deceased's state of health, employment, finances or insurance, advice, treatment provided to the deceased or any information that may be required concerning the health of the deceased including information relating to mental illness, use of drugs, use of alcohol. A copy of this authorization shall be considered as effective and valid as the original.

e. I do hereby authorize Subrogation Agency to inquire and obtain any information regarding my accident. Further, the Company is hereby authorized to release any and all information, including copies of pertinent documents, which Subrogation Agency may deem necessary in order to satisfy their inquiry, If during the investigation, Subrogation Agency has identified a potential recovery source, allowing the Plan Participant's employer to recover paid benefits, Subrogation Agency is authorized to release any all records they deem necessary in order to pursue the recovery

Place: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date: ☐☐☐☐☐☐☐☐

Signature of the Claimant