Broad Guidelines for Claim Process

1. Please ensure Claim form is completely filled, signed and **submitted in original.**
2. Please provide at least **two contactable mobile numbers and e-mail id** for further communication related to your claim.
3. Indicative list of claim documents has been provided in the Claim Form under Section E. **Please ensure all the documents are submitted in original for smooth processing of claim.**
4. **Claim processing will be delayed in absence of original documents.**
5. **Claim payments are made only through Online Bank Transfers.** Please submit the Bank Account details along with a cancelled cheque. The bank accounts details need to be mentioned in Section G of the Claim Form.

In addition to above, if the claim amount is more than Rs 1 Lakh then following additional documents are required:

6. KYC Documents (If Applicable)

Claim documents needs to be send on below address: -

Care Health Insurance-Claims Department

Vipul Tech Square, Tower C, 3rd Floor, Golf Course Road,

Sector-43, Gurugram-122009 (Haryana)

Now, track your claim status with ease

ONLINE : Please visit below link and enter your Client ID and Policy Number

www.careinsurance.com/claim_search.php **Center/Claim Search/Enter Client ID and Policy No.**

SMS : Simply SMS your claim reference number in the message format CLAIM <space> CLAIM NUMBER to 77158-77158

Example: To check claim status of claim reference number 11223344, simply SMS CLAIM 11223344 to 77158-77158

Brief description of the key documents required along with the claim form

1. Indoor Case Papers - This document is prepared by hospital on daily basis which maintains daily doctor notes, nursing notes, patient progress details and having patient condition summary from the date of admission till discharge.
2. Hospital Discharge Summary - Summary of hospitalization period including - Admission date, discharge date, diagnosis, line of treatment given to patient during hospitalization and further advice on discharge.
3. Payment Receipts - Receipts of payment done to hospital authorities towards all bills, investigation reports or any other procedure done.
4. Consultation Papers - Written prescription of the Medical Practitioner with whom patient has consulted.
5. NEFT (Net Electronic Fund Transfer) – We require original cancelled cheque of the policyholder and relevant details to be mandatorily filled under Sector-G of claim form.

Terms and Conditions for Payments through RTGS/NEFT

1. The details provided by the policyholder in the mandate form shall be considered as final and Care Health Insurance Limited shall not be responsible for cross verifying of any of the details provided therein.
2. The policy holder agrees that transaction through RTGS/NEFT facility may attract inward RTGS/NEFT charges, which if levied by the policyholder's bank shall be borne by the policy holder only.
3. Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company.
4. I/We further undertake to refund any excess amount whether demanded by Care Health Insurance Limited or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from Care Health Insurance Limited of such excess credit or such information of excess credit coming to the knowledge of the policy holder through any other source.
5. The policyholder agrees that under RTGS/NEFT facility, there may be risk of non-payment in the policyholder accounts number on the day of the credit of payments due to change in the applicable regulations pertaining to RTGS/NEFT facility or due to any other reasons without any fault/inaction/failure on part of Care Health Insurance Limited or any factor beyond the control of Care Health Insurance Limited.

Claim Form - 'STUDENT EXPLORE'

Note: The issue of this form shall not to be taken or deemed to be taken as an admission of liability by the Company.

Please Note:

1. Please give the required information correctly and completely so as to enable us to process your claims promptly.
2. Use additional sheets, if required.
3. We may ask for additional documents/ information as relevant.
4. The claim form should be supported by all the documents as specified in the Policy.

Section A - Details of the Policy

a) Policy No. :

b) Insured Name :

(Surname) (First Name) (Middle Name)

c) Policy Certificate No.:

Section B - Details of Insured Person / Claimant (In case of Insured's Death)

Title : ☐ Mr. ☐ Ms.

a) Name :

(Surname) (First Name) (Middle Name)

b) Address :

(if different from above)

City : State :

Country : Pin Code :

c) Landline : - Mobile :

d) E-mail :

e) Relationship with the Student : ☐ Self ☐ Spouse ☐ Child

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 :-

Benefit		Benefit	
In-patient Care	☐	Daily Allowance	☐
Pre-Existing Disease Cover in Life Threatening Medical Condition	☐		
Extended Cover in the Country of Residence	☐		
Out-Patient Care	☐	Self-Inflicted Injury	☐
HIV/AIDS Cover	☐	Treatment for Mental and Nervous Disorder	☐
Treatment for Alcoholism and Drug Dependency	☐	Cancer screening and Mammographic Examination	☐
Adventure Sports Injury	☐	Vision Care	☐
Home Care	☐	Maternity Cover	☐
Maternity and New Born Cover	☐	Coverage at home country	☐
Medical Evacuation	☐	Dental Treatment	☐

Name, address and telephone number of Hospital where treatment was given: ______________________

____

Name of treating doctor/dental surgeon: ______________________

Details of Illness/Injury: ______________________

____

Cause of the Illness/Injury: ______

Was the Illness/incident caused/ aggravated due to a pre-existing condition? Please give details: ______

Date of onset of Illness (DDMMYYYY): ☐☐ ☐☐ ☐☐☐☐

Nature of treatment: ______

Date of treatment (DDMMYYYY): From ☐☐ ☐☐ ☐☐☐☐ To ☐☐ ☐☐ ☐☐☐☐

Reason for Medical Evacuation (If Medical Evacuation) ______

Medical Evacuation From: ______ To: ______ Date: ☐☐ ☐☐ ☐☐☐☐

Serial no.	Expense Details	Amount

Repatriation of Mortal Remains ☐

Cause of death: ______

Date of death of Insured (DDMMYYYY): ☐☐ ☐☐ ☐☐☐☐ Total expenses ______

Transportation From: ______ To: ______ Date: ☐☐ ☐☐ ☐☐☐☐

Loss of Checked-in Baggage ☐ **Delay of Checked-in Baggage** ☐

Name of Common Carrier ______

In case of loss of checked-in Baggage

Date of loss (DDMMYYYY): ☐☐ ☐☐ ☐☐☐☐ Place of loss: ______

In case of delay of checked-in Baggage

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

Emergency Cash Advance ☐ **Loss of International Driving License** ☐ **Personal Liability** ☐ **Loss of Passport** ☐

Date of loss (DDMMYYYY): ☐☐ ☐☐ ☐☐☐☐ Place of loss: ______

Detail of loss: ______

Name of aggrieved third party (in case of Personal Liability): ______ Total expenses: ______

Accidental Death ☐ **Permanent Total Disablement** ☐ **Permanent Partial Disablement** ☐

Cause of Accident: ______

Nature of loss/ Injury: ______

Place of Accident: ______ Details of Common Carrier: ______

Name, address and telephone number of hospital/clinic where treatment was given: ______

Name of treating doctor : ____________________

Date of medical/surgical treatment (DDMMYYYY): From ☐☐ ☐☐ ☐☐☐☐ To ☐☐ ☐☐ ☐☐☐☐

Date of death, if applicable (DDMMYYYY): ☐☐ ☐☐ ☐☐☐☐

Extent of disability, if applicable : ____________________

Trip Delay ☐

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: ____________

Description of incident : ____________________

Total expenses ____________

Compassionate Visit ☐

Name, address and telephone number of hospital/clinic where treatment was given : ____________________

____

Name of treating doctor : ____________________

Details of Illness : ____________________

____

Cause of the Illness : ____________________

____

Nature of treatment : ____________________

____

Date of Hospitalization (DDMMYYYY) : ☐☐ ☐☐ ☐☐☐☐

Treating doctor's opinion on how many more days the patient will need to be hospitalized : ☐☐☐☐

Treating doctor's opinion on why the patient cannot be sent back to Country of Residence for further treatment : ____________________

____

Treating doctor's opinion on need for an attendant : ____________________

Details of journey : From ____________ To ____________

Total expenses ____________

Loss of Laptop / Tablet ☐

Loss date (DDMMYYYY) : ☐☐ ☐☐ ☐☐☐☐

Reason for loss : ____________________

____

Details of expenses incurred : ____________________

Total expenses ____________

Bail Bond ☐

Name and contact details of the detaining authority : ______

The offence for which Insured is in custody : ______

Is this offence bailable as per the laws of the detaining country? : ☐ Yes ☐ No

Total expenses ______

Sponsor Protection ☐

Name of the sponsor : ______

Cause of accident causing demise of the sponsor : ______

Nature of Injury causing the demise of the sponsor : ______

Place of accident of the sponsor : ______

Name, address and telephone number of hospital/clinic where treatment was given to the sponsor : ______

Name of treating doctor of the sponsor : ______

Details of medical/surgical treatment given to sponsor : ______

Date of medical/surgical treatment (DDMMYYYY): From ☐☐ ☐☐ ☐☐☐☐ To ☐☐ ☐☐ ☐☐☐☐

Date of Accidental Death (DDMMYYYY): ☐☐ ☐☐ ☐☐☐☐

Study Interruption ☐

Due to Hospitalization of the Insured ☐

Name, address and telephone number of hospital/clinic where treatment is being given : ______

Name of treating doctor : ______

Details of Illness : ______

Cause of the Illness : ______

Nature of treatment : ______

Dates of Hospitalization (DDMMYYYY): From ☐☐ ☐☐ ☐☐☐☐ To ☐☐ ☐☐ ☐☐☐☐

Reason for medical evacuation (if applicable) : ______

Reason for not continuing studies abroad : ______

Tuition Fees paid in advance for the year : ☐☐☐☐☐☐☐

Due to death of immediate family member: ☐

Name of the immediate family member : ______

Cause of accident causing demise of the immediate family member : ______

Nature of Injury causing the demise of the immediate family member : ______

Place of accident of the immediate family member : ______

Name, address and telephone number of hospital/clinic where treatment was given to the immediate family member : ______

Name of treating doctor of the immediate family member : ______

Details of medical/surgical treatment given to immediate family member : ______________________________

____

Dates of medical/surgical treatment (DDMMYYYY): From ☐☐ ☐☐ ☐☐☐☐ To ☐☐ ☐☐ ☐☐☐☐

Reason for not continuing studies abroad : ______________________________

Tuition Fees paid in advance for the year : ☐☐☐☐☐☐

University Insolvency ☐

Name of the University : ______________________________

FIR / Complaint date and Number : ______________________________

Details of expenses incurred : ______________________________

Section D - Declaration by the Insured

I/We here by 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 with held 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.

Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Signature of the Claimant : ______________________________

Place : ______________________________

(xi) Details of Expenses

Booking Reference No.	Expense Details	Booking Amount	Refund Amount	Expenses incurred (in

(xii) Total Expenses : ______________________________

(vi) Documents to be submitted for any claim under Benefit 11 :

1) Confirmation in writing of cancellation of the journey from the Common Carrier detailing the circumstances of cancellation.

2) Ticket/boarding pass issued by the Common Carrier indicating the cost of ticket and receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the journey indicating cancellation charges retained by the Common Carrier.

3) Boarding pass in original for return journey from the place of cancellation to the Country of Residence which indicates the cost of the tickets together with the receipts for the refunds obtained towards the unfulfilled portion of the journey.

4) A declaration from the Insured Person furnishing the circumstances that compelled him/her to cancel the journey.

5) Medical evidence as may be required in case of the cancellation of the journey arising out of personal contingencies of the Insured Person or his/her Immediate Family Member.

6) Receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the journey indicating the cancellation charges retained.

k) Additional Details for Benefit 12

(i) Name of the Common Carrier : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(ii) Common Carrier No. : ☐☐☐☐☐☐☐☐☐☐

(iii) Scheduled Arrival Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Time : ☐☐ : ☐☐ (HH:MM)

(iv) Scheduled Departure Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Time : ☐☐ : ☐☐ (HH:MM)

(v) Name of the Common Carrier: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(vi) Common Carrier No. : ☐☐☐☐☐☐☐☐☐☐

(vii) Actual Arrival Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Time : ☐☐ : ☐☐ (HH:MM)

(viii) Actual Departure Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Time : ☐☐ : ☐☐ (HH:MM)

l) Additional Details for Benefit 13 & Benefit 14

(i) Name of the Common Carrier: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(ii) Common Carrier No. : ☐☐☐☐☐☐☐☐☐☐

(iii) In case of Loss of Baggage

a) Date of Loss : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) (b) Place of Loss : ____________________

(iv) In case of Delay

a) Date of Arrival : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) (b) Time of Arrival : ☐☐ : ☐☐ (HH:MM)

c) Place of Origin : ______________________________ (d) Port of disembarkation : ______________

e) Date of Baggage retrieval : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

f) Time of Baggage retrieval : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

(v) Documents to be submitted for any claim under Benefit 13 :

1) Property irregularity report issued by the appropriate authority.

2) Voucher of the Common Carrier for the compensation paid for the non-delivery/short delivery of the Checked-In Baggage.

3) Copies of correspondence exchanged, if any, with the Common Carrier in connection with the non-delivery/short delivery of the Checked-In Baggage.

(vi) Documents to be submitted for any claim under Benefit 14

4) Property irregularity report issued by the appropriate authority stating the scheduled time of delivery and actual time of delivery of the Checked-In Baggage.

5) Voucher of the Common Carrier for the compensation paid for the delay in delivery of the Checked-In Baggage.

6) Copies of correspondence exchanged, if any, with the Common Carrier in connection with the delay in delivery of the Checked-In Baggage.

m) Additional Details for Benefit 15 & Benefit 16

(i) Date of Loss : __ __ / __ __ / __ __ __ __ (DD/MM/YYYY) (ii) Place of Loss : ____________________

(iii) Details of Loss : ____________________

(iv) Total Expenses : ____________________

(v) Documents to be submitted for any claim under Benefit 15 :

1) Copy of the police report.

2) Details of the attempts made to trace the passport.

3) Original receipt for payment of charges to the authorities for obtaining a new or duplicate passport.

(vi) Documents to be submitted for any claim under Benefit 16 :

1) Statement of Claim furnishing particulars of the event leading to the liability such as the court order.

2) Photocopy of the police report (wherever reported).

Section F - Details of Bills Enclosed

S No.	Bill No.	Date	Issued by	Towards	Amount (INR)
1		(DD/MM/YYYY)		Hospital Main Bill	
2		(DD/MM/YYYY)		Pre-hospitalization Bills: ____Nos	
3		(DD/MM/YYYY)		Post-hospitalization Bills: ___Nos	
4		(DD/MM/YYYY)		Pharmacy bills	
5		(DD/MM/YYYY)			
6		(DD/MM/YYYY)			
7		(DD/MM/YYYY)			
8		(DD/MM/YYYY)			
9		(DD/MM/YYYY)			
10		(DD/MM/YYYY)			

Section G - Details of Primary Insured's Bank Account

a) PAN :

b) Account Number :

c) Bank Name & Branch :

d) Cheque/DD payable details :

e) IFSC Code :

Section H - Declaration by the Insured

a) I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize assistant service provider/insurance company, to seek necessary medical information/documents from any hospital/ Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills/receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

b) I hereby authorize the Company or its Assistance Service Provider to conduct Autopsy/Post Mortem for the Insured Person, wherever required.

c) 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.

Date : __ __ / __ __ / __ __ __ __ (DD/MM/YYYY) Signature of the Insured : ____________________

Place : ____________________

Guidance For Filling Claim Form- Part A (To be filled in by the insured)

Data Element	Description	Format
Section A - Details of Primary Insured		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No.	License number as allotted by IRDA and printed in TPA documents
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin Code
Section B - Details of Insurance History		
a) Currently covered by any other Mediclaim/Health Insurance?	Indicate whether currently covered by another Mediclaim/Health Insurance	Tick Yes or No
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name	Enter the full name of the insurance company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalised in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Mediclaim/Health Insurance?	Indicate whether previously covered by another Mediclaim/Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
Section C - Details of Insured Person Hospitalised		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship with primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Landline	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
Section D - Details of Hospitalisation		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
I) If Injury give cause	Indicate cause of injury	Tick the right option
Medico legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
Section E - Details of Claim		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/cash benefit claimed	Enter the amount claimed as lump sum/cash benefit	In rupees (Do not enter paise values)
d) Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
e) Additional Details for Benefit 3 & Benefit 4		
(i) Cause of the Illness/Injury	Enter the cause of Illness/Injury	Open Text
(ii) Was the Illness/incident caused/ aggravated due to a pre-existing condition?	Indicate whether due to a pre-existing condition	Tick the right option
Give details	Enter the details of the pre-existing condition	Open Text
(iii) Nature of treatment	Enter the nature of treatment	Open Text

Data Element	Description	Format
(iv) Treating Doctor's opinion on how many more days the patient will need to be hospitalized	Enter the number of days	In Days
(v) Treating Doctor's opinion on why the patient cannot be sent back to Country of Residence of the Insured Person for further treatment	Enter Treating Doctor's opinion	Open Text
(vi) Treating Doctor's opinion on need for an attendant	Enter Treating Doctor's opinion	Open Text
(vii) Name of the Attendant/Staff	Enter the Name of the Attendant/Staff	Name of the Attendant/Staff
(viii) Name of the Child who shall return	Enter the Name of the Child who shall return	Name of the Child who shall return
(ix) Details of Journey	Enter the Details of Journey	Open Text
(x) Date of Journey	Enter the relevant date	Use dd-mm-yy format
(xi) Total Expenses	Enter the amount claimed as total expenses	In rupees (Do not enter paise values)
(xii) Documents to be submitted for any claim under Benefit 3		
(xiii) Documents to be submitted for any claim under Benefit 4		
f) Additional Details for Benefit 5		
(i) Details of Journey	Enter the Details of Journey	Open Text
(ii) Date of Journey	Enter the relevant date	Use dd-mm-yy format
(iii) Total Expenses	Enter the amount claimed as total expenses	In rupees (Do not enter paise values)
(iv) Documents to be submitted for any claim under Benefit 5		
g) Additional Details for Benefit 7 & Benefit 8		
(i) Cause of Accident	Enter the cause of accident	Open Text
(ii) Nature of Loss	Enter the Nature of Loss	Open Text
(iii) Place of Loss	Enter the Place of Loss	Place of Loss
(iv) Name of the Common Carrier	Enter the Name of the Common Carrier	Name of the Common Carrier
(v) Common Carrier No.	Enter the Common Carrier No.	Common Carrier No.
(vi) Documents to be submitted for any claim under Benefit 7		
(vii) Documents to be submitted for any claim under Benefit 8		
h) Additional Details for Benefit 9		
(i) Reason for Medical Evacuation	Enter the Reason for Medical Evacuation	Open Text
(ii) Medical Evacuation	Enter the relevant dates	Use dd-mm-yy format
(iii) Total Expenses	Enter the amount claimed as total expenses	In rupees (Do not enter paise values)
(iv) Documents to be submitted for any claim under Benefit 9		
i) Additional Details for Benefit 10		
(i) Cause of Death	Enter the Cause of Death	Open Text
(ii) Date of Death	Enter the relevant date	Use dd-mm-yy format
(iii) Place of Death	Enter the Place of Death	Place of Death
(iv) Transportation	Enter the Transportation details	Transportation details
(v) Total Expenses	Enter the amount claimed as total expenses	In rupees (Do not enter paise values)
(vi) Documents to be submitted for any claim under Benefit 10		
j) Additional Details for Benefit 11		
(i) Reason for Trip Cancellation or Interruption	Indicate the reason	Open Text
(ii) Name of the Common Carrier	Enter the Name of the Common Carrier	Name of the Common Carrier
(iii) Common Carrier No.	Enter the Common Carrier No.	Common Carrier No.
(iv) Scheduled Arrival Date	Enter the relevant date	Use dd-mm-yy format
(v) Scheduled Departure Date	Enter the relevant date	Use dd-mm-yy format
(vi) Name of the Common Carrier	Enter the Name of the Common Carrier	Name of the Common Carrier
(vii) Common Carrier No.	Enter the Common Carrier No.	Common Carrier No.
(viii) Actual Arrival Date & Time	Enter the relevant date & time	Use dd-mm-yy format
(ix) Actual Departure Date& Time	Enter the relevant date & time	Use dd-mm-yy format
(x) Description of Incident	Enter the Description of Incident	Open Text
(xi) Details of Expenses		
Booking Reference No.	Enter the Booking Reference No.	As allotted by the Airline/Hotel/etc.
Expense details	Enter the expenses details	Open Text
Booking Amount	Enter the Booking Amount	In rupees (Do not enter paise values)
Refund Amount	Enter the Refund Amount	In rupees (Do not enter paise values)
Expenses incurred	Enter the expenses incurred	In rupees (Do not enter paise values)
(xii) Total Expenses	Enter the amount claimed as total expenses	In rupees (Do not enter paise values)

Data Element	Description	Format
(xiii) Documents to be submitted for any claim under Benefit 11		
k) Additional Details for Benefit 12		
(i) Name of the Common Carrier	Enter the Name of the Common Carrier	Name of the Common Carrier
(ii) Common Carrier No.	Enter the Common Carrier No.	Common Carrier No.
(iii) Scheduled Arrival Date & Time	Enter the relevant date & time	Use dd-mm-yy format
(iv) Scheduled Departure Date & Time	Enter the relevant date & time	Use dd-mm-yy format
(v) Name of the Common Carrier	Enter the Name of the Common Carrier	Name of the Common Carrier
(vi) Common Carrier No.	Enter the Common Carrier No.	Common Carrier No.
(vii) Actual Arrival Date & Time	Enter the relevant date & time	Use dd-mm-yy format
(viii) Actual Departure Date & Time	Enter the relevant date & time	Use dd-mm-yy format
l) Additional Details for Benefit 13 & Benefit 14		
(i) Name of the Common Carrier	Enter the Name of the Common Carrier	Name of the Common Carrier
(ii) Common Carrier No.	Enter the Common Carrier No.	Common Carrier No.
(iii) In case of Loss of Baggage		
a. Date of Loss	Enter the relevant date	Use dd-mm-yy format
b. Place of Loss	Enter the place of loss	Place of Loss
(iv) In case of Delay		
a. Date of Arrival	Enter the relevant date	Use dd-mm-yy format
b. Time of Arrival	Enter the relevant time	Use hh:mm format
c. Place of origin	Enter the Place of origin	Place of origin
d. Port of disembarkation	Enter the Port of disembarkation	Port of disembarkation
e. Date of baggage retrieval	Enter the relevant date	Use dd-mm-yy format
f. Time of baggage retrieval	Enter the relevant time	Use hh:mm format
(v) Documents to be submitted for any claim under Benefit 13		
(vi) Documents to be submitted for any claim under Benefit 14		
m) Additional Details for Benefit 15 & Benefit 16		
(i) Date of Loss	Enter the relevant date	Use dd-mm-yy format
(ii) Place of Loss	Enter the place of loss	Place of loss
(iii) Details of Loss	Enter the details of loss	Open Text
(iv) Total Expenses	Enter the amount claimed as total expenses	In rupees (Do not enter paise values)
(v) Documents to be submitted for any claim under Benefit 15		
(vi) Documents to be submitted for any claim under Benefit 16		
Section F - Details of Bill Enclosed		
Indicate which bills are enclosed with the amounts in rupees		
Section G - Details of Primary Insured's Bank Account		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) Cheque/DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/organization in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
Section H - Declaration by the Insured		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		