IFFCO-TOKIO GENERAL INSURANCE CO. LTD

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi-110017

Overseas Travel Protector
UIN: IFFTIOP27045V012627

Claim Form

NAME OF THE CLAIMANT (IN FULL)				
ADDRESS		Policy Number		
ADDRESS DATE OF BIRTH		PLAN TYPE		
		PERIOD OF INSURANCE	FROM	
			TO	
MOBILE NO.		GENDER		
EMAIL ID		PASSPORT NO.		
OCCUPATION				
OCCUPATION RELATIONSHIP OF THE CLAIMANT WITH THE INSURED PERSON		DATE TRIP COMMENCED		
RELATIONSHIP OF THE CLAIMANT WITH THE INSURED PERSON GUIDELINES TO FILL THE FORM (PLEASE TICK WHICHEVER IS APPLICABLE AND FILL THE DETAILS AS APPLICABLE.)		DATE OF SCHEDULED RETURN		
□ Health Cover:				
○Medical Expenses (Incl. OPD)				
○Medical Evacuation				
○ Transportation to the Country of Residence				
○ Balance Period of Policy +30 days				
○ Repatriation of Mortal Remains				
□ Hospital daily Allowance				
□ Dental Treatment				
□ Compassionate Visit				
□ Accidental Death (Common Carrier)				

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□ Personal Accident (Death, Permanent Disablement)
□ Return of Minor Child(ren)
□ Delay of Checked in Baggage
□ Total Loss of Checked in Baggage
□ Hijack Distress Allowance
□ Missed Flight Connection
□ Loss of Passport/ International Driving License/ Any other govt ID
□ Trip Cancellation & Interruption
□ Trip Delay
□ Bounced Booking of Airline / Hotel
□ Personal Liability
□ Loss of Baggage and Personal Belongings
□ Financial Assistance
□ Emergency Hotel Accommodation
□ Fire Cover
a. Fire Cover for Building
b. Fire Cover for Contents
□ Burglary Cover for Home Contents
□ Automatic Trip Extension
□ Refund of Visa Fee
□ Adventure Sports
ALL CLAIMS HAVE TO BE SUPPORTED WITH ORIGINAL DOCUMENTS OF EXPENSES / COSTS INCURRED, WHEREVER APPLICABLE
HEALTH COVER (PLEASE ATTACH ORIGINAL DOCTOR'S CERTIFICATE, TEST REPORTS AND HOSPITAL PAPERS INCLUDING DISCHARGE CARD)
MEDICAL EXPENSES /DENTAL TREATMENT / BALANCE PERIOD OF POLICY +30 DAYS
NAME OF DISEASE CONTRACTED

NAME OF DISEASE CONTRACTED WHEN DISEASE FIRST MANIFESTED		TREATING DOCTOR / CLINIC / HOSPITAL NAME	
WHEN DISEASE FIRST MANIFESTED DATE WHEN TREATMENT STARTED	DD/MM/YY	ADDRESS	

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DATE WHEN TREATMENT STARTED DATE WHEN TREATMENT ENDED	DD/MM/YY	CONTACT NUMBER	
DATE WHEN TREATMENT ENDED DATE OF ADMISSION	DD/MM/YY	NATURE OF DISEASE/INJURY (PLEASE DESCRIBE BRIEFLY)	
DATE OF ADMISSION DATE OF DISCHARGE	DD/MM/YY		
DATE OF DISCHARGE HOSPITAL EXPENSES (PLEASE SHOW EACH HEAD SEPARATELY)	DD/MM/YY		
ROOM RENT			
CONSULTANCY CHARGES			
COST OF TESTS			
OTHER COSTS			
OUTPATIENT EXPENSES			
TOTAL CLAIM AMOUNT:			
B. HOSPITAL DAILY ALLOWANCE		TOTAL CLAIM AMOUNT IN WORDS:	
TOTAL NUMBER OF DAYS FOR AMOUNT BEING CLAIMED FOR			
TOTAL CLAIM AMOUNT:			
C.TRANSPORTATION/REPARIATION OF MORTAL REMAINS/ MEDICAL EVACUATION/RETURN OF MINOR		TOTAL CLAIM AMOUNT IN WORDS:	
IF YOU ARE CLAIMING FOR EXTRA COSTS OF TRANSPORTATION HOME (FOR SELF AND / OR ACCOMPANYING PERSON), RETURN OF MINOR CHILD(REN), MORTAL REMAINS OR BURIAL EXPENSES PLEASE SPECIFY THE NAME OF AIRLINES, BURIAL DETAILS, EXPENSES INCURRED AND OTHER INCIDENTAL COSTS WITH BIFURCATION OF EXPENSES IN AN ATTACHED SHEET.			
IF YOU ARE CLAIMING FOR EXTRA COSTS OF TRANSPORTATION HOME (FOR SELF AND / OR ACCOMPANYING PERSON), RETURN OF MINOR CHILD(REN), MORTAL REMAINS OR BURIAL EXPENSES PLEASE SPECIFY THE NAME OF AIRLINES, BURIAL DETAILS, EXPENSES INCURRED AND OTHER INCIDENTAL COSTS WITH BIFURCATION OF EXPENSES IN AN ATTACHED SHEET. TOTAL CLAIM AMOUNT:			
HIJACK DISTRESS ALLOWANCE (Please attach necessary evidence such as Police Report, Airlines Report, Media & TV coverage Reports)		TOTAL CLAIM AMOUNT IN WORDS:	

HIJACK DISTRESS ALLOWANCE (Please attach necessary evidence such as Police Report, Airlines Report, Media & TV coverage Reports) NAME OF THE AIRLINE						
NAME OF THE AIRLINE	DATE OF COMMENCEMENT OF TRAVEL	FLIGHT NUMBER	ROUTE BEING FOLLOWED WHEN HIJACK TOOK PLACE		ARRIVAL TIME	
					SCHEDULED	ACTUAL
TOTAL CLAIM AMOUNT			FROM	TO		
TOTAL CLAIM AMOUNT **FINANCIAL ASSISTANCE (Please attach Police Report)**			TOTAL CLAIM AMOUNT IN WORDS			
AMOUNT OF FUNDS LOST						
AMOUNT OF FUNDS LOST IN WORDS			PLACE OF LOSS			
POLICE REPORT LODGED			DATE OF LOSS	DD/MM/YY		
TOTAL CLAIM AMOUNT:	YES/NO		TIME OF LOSS			
LOSS OF CHECKED BAGGAGE / DELAY OF CHECKED BAGGAGE / LOSS OF BAGGAGE AND PERSONAL BELONGINGS (Please attach Police Report, Property Irregularity Report from the Carrier, Claim Lodged on the Carrier, Baggage Receipt, Money Receipts of essential items purchased)	TOTAL CLAIM AMOUNT IN WORDS:					
LOSS OF CHECKED BAGGAGE / DELAY OF CHECKED BAGGAGE / LOSS OF BAGGAGE AND PERSONAL BELONGINGS (Please attach Police Report, Property Irregularity Report from the Carrier, Claim Lodged on the Carrier, Baggage Receipt, Money Receipts of essential items purchased) **TOTAL LOSS OF CHECKED BAGGAGE**						
PROPERTY IRREGULARITY REPORT BY CARRIER ATTACHED			**DELAY OF CHECKED BAGGAGE**			
CLAIM LODGED ON CARRIER	YES/NO		NAME OF THE AIRLINE			
POLICE REPORT LODGED	YES/NO		FLIGHT NUMBER			
NUMBER AND DESCRIPTION OF ITEMS LOST	YES/NO		SCHEDULED DEPARTURE	DATE	DD/MM/YY	
NUMBER AND DESCRIPTION OF ITEMS LOST COST OF ITEMS LOST				TIME		
			SCHEDULED ARRIVAL	DATE	DD/MM/YY	
				TIME		
COST OF ITEMS LOST DESCRIPTION OF ITEMS PURCHASED			ACTUAL DEPARTURE	DATE	DD/MM/YY	
				TIME		

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DESCRIPTION OF ITEMS PURCHASED COST OF ITEMS PURCHASED		ACTUAL ARRIVAL	DATE	DD/MM/YY	
			TIME		
TOTAL CLAIM AMOUNT:					
LOSS OF PASSPORT/ INTERNATIONAL DRIVING LICENCE/ ANY OTHER GOVT ID (Please attach Police Report, Proof of Expenditure)		TOTAL CLAIM AMOUNT IN WORDS:			
DATE OF LOSS					
APPLICATION/DOCUMENTATION FEE	DD/MM/YY	POLICE REPORT LODGED	YES/NO		
APPLICATION/DOCUMENTATION FEES IN WORDS		INCIDENTAL COSTS			
TOTAL CLAIM AMOUNT:		INCIDENTAL COSTS IN WORDS			
PERSONAL ACCIDENT & ACCIDENTAL DEATH (Please attach Police Report, Post Mortem Report, Death Certificate, Medical Report)		TOTAL CLAIM AMOUNT IN WORDS:			
DATE					
TREATING DOCTOR/CLINIC/HOSPITAL		TIME		PLACE OF ACCIDENT	
NAME				POLICE REPORT LODGED	YES/NO
ADDRESS				FULL DESCRIPTION OF ACCIDENT CAUSE	
ADDRESS CONTACT NUMBER					
NATURE OF INJURY SUSTAINED					
TOTAL CLAIM AMOUNT:					
PERSONAL LIABILITY (Please attach Judgment of the Court)		TOTAL CLAIM AMOUNT IN WORDS:			
DATE					
NATURE OF	DD/MM/YY	TIME		PLACE OF ACCIDENT	

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CLAIM BEING MADE					
NATURE OF CLAIM BEING MADE TOTAL AMOUNT OF AWARD INCLUDING CLAIMANT COST				COURT WHERE THE CASE IS BEING PURSUED	
TOTAL AMOUNT OF AWARD INCLUDING CLAIMANT COST **TRIP DELAY/TRIP CANCELLATION & INTERRUPTION/MISSED FLIGHT CONNECTION (Please attach relevant certificate from the Airlines, reason along with proof, document supporting claimed amount)**				TOTAL AMOUNT OF AWARD INCLUDING CLAIMANT COST IN WORDS	

TRIP DELAY/TRIP CANCELLATION & INTERRUPTION/MISSED FLIGHT CONNECTION (Please attach relevant certificate from the Airlines, reason along with proof, document supporting claimed amount) NAME OF AIRLINES					
FLIGHT NUMBER:					
SCHEDULED DEPARTURE		FROM:		TO:	
SCHEDULED DEPARTURE SCHEDULED ARRIVAL	DATE	DD/MM/YY	ACTUAL DEPARTURE	DATE	DD/MM/YY
	TIME			TIME	
SCHEDULED ARRIVAL DEPATURE OF CONNECTING FLIGHT	DATE	DD/MM/YY	ACTUAL ARRIVAL	DATE	DD/MM/YY
	TIME			TIME	
DEPATURE OF CONNECTING FLIGHT DETAILS OF LOSSES/EXPENSES INCURRED	DATE		CAUSE OF DELAY		
	TIME				
DETAILS OF LOSSES/EXPENSES INCURRED TOTAL CLAIM AMOUNT:	SR.NO.	DETAILS		AMOUNT	

COMPASSIONATE VISIT (Please provide Proof of relationship with insured member, medical certificate from the attending practitioner stating hospitalization exceeding 7 days and need for family member's visit.)		TOTAL CLAIM AMOUNT IN WORDS:		
COMPASSIONATE VISIT (Please provide Proof of relationship with insured member, medical certificate from the attending practitioner stating hospitalization exceeding 7 days and need for family member's visit.) DATE OF COMMENCEMENT OF TRIP				
DATE OF COMMENCEMENT OF TRIP DATE OF HOSPITAIZATION		DESTINATION COUNTRY		
DIAGNOSIS	DD/MM/YY	PLACE OF HOSPITALIZATION		NAME &CONTACT OF HOSPITAL
NAME AND CONTACT NO. OF THE TREATING DOCTOR				
NAME AND CONTACT NO. OF THE TREATING DOCTOR IS THERE ANY OTHER ADULT TRAVELING COMPANION WITH THE INSURED MEMBER				
TRAVEL DATES		YES/ NO	NAME AND RELATION SHIP OF VISTOR	
BOUNCED BOOKING OF AIRLINE/HOTEL (Please provide original letter confirming amount paid, confirming cancellation, refund details (if any), supporting documents to establish loss with bills and receipts)				

BOUNCED BOOKING OF AIRLINE/HOTEL (Please provide original letter confirming amount paid, confirming cancellation, refund details (if any), supporting documents to establish loss with bills and receipts) DATE OF COMMENCEMENT OF TRIP						
ORIGINAL TRAVEL DATES		DESTINATION COUNTRY		PURPOSE OF TRAVEL		
BOOKING BOUNCE DATE	FROM:		TO:			
TYPE OF BOUNCED BOOKING	DD/MM/YY					
TYPE OF BOUNCED BOOKING BOOKING REFERENCE NUMBER	AIRLINES/HOTEL	NAME OF AIRLINES/HOTEL				
DESCRIPTION OF INCIDENT		BOOKING DATE		SCHEDULED TRAVEL/CHECK IN DATE		
DESCRIPTION OF INCIDENT REASON GIVEN BY CARRIER/HOTEL FOR BOUNCED BOOKING						
WAS THE BOUNCED BOOKING DUE TO						
WAS THE BOUNCED BOOKING DUE TO DETAILS OF ALTERNATIVE TRAVEL/ACCOMODATION	COMMON CARRIER/PUBLIC CARRIER DECISION			DETAILS OF ALTERNATIVE ARRANGEMENT		
	ACCOMODATION PROVIDER'S DECISION					
SAME CLASS OF TRAVEL/CATEGORY OF ACCOMODATION						
DETAILS OF LOSSES/EXPENSES INCURRED	YES/NO	NAME OF ALTERNATIVE PROVIDER				
DETAILS OF LOSSES/EXPENSES INCURRED TOTAL AMOUNT	SR.NO.	LOSS DETAILS		AMOUNT		
COST OF ORIGINAL BOOKING			TOTAL AMOUNT IN WORDS:			

ADDITIONAL EXPENSES INCURRED	USD/INR		COST OF ALTERNATIVE BOOKING	USD/INR	
EMERGENCY HOTEL ACCOMODATION (Please provide written confirmation on reason for vacating from the original accommodation, bills and receipts as proof)	USD/INR		AMOUNT CLAIMED		
EMERGENCY HOTEL ACCOMODATION (Please provide written confirmation on reason for vacating from the original accommodation, bills and receipts as proof) DATE & PLACE OF INCIDENCE					
DURATION OF STAY IN EMERGENCY ACCOMODATION			REASON FOR EMERGENCY ACCOMODATION		
DURATION OF STAY IN EMERGENCY ACCOMODATION COST OF ORIGINAL ACCOMMODATION	FROM: TO:	NAME AND ADDRESS OF EMERGENCY ACCOMODATION			
COST OF ORIGINAL ACCOMMODATION COST OF EMERGENCY ACCOMADATION	USD/INR				
COST OF EMERGENCY ACCOMADATION AMOUNT CLAIMED	USD/INR				
		ADDITIONAL EXPENSES INCURRED	USD/INR		
FIRE COVER (Home Building & contents)		USD/INR			
FIRE COVER (Home Building & contents) TYPE OF PROPERTY					
TYPE OF PROPERTY **INCIDENT DETAILS**	Dwelling (Building) Household Contents (including valuable contents)		Description of Valuable Contents		
DATE AND TIME OF LOSS/DAMAGE					
DATE AND TIME OF LOSS/DAMAGE DESCRIPTION OF INCIDENT		LOCATION OF LOSS/DAMAGE		CAUSE OF LOSS/DAMAGE	
DESCRIPTION OF INCIDENT LOSS DETAILS					
LOSS DETAILS	ITEM		AMOUNT	TOTAL AMOUNT	

BURGLARY COVER FOR HOME CONTENTS			

BURGLARY COVER FOR HOME CONTENTS INCIDENT DETAILS					
DATE OF LOSS					
	TIME OF LOSS	PLACE OF LOSS	BRIEF DESCRIPTION OF INCIDENT		
FIR/ POLICE REPORT NO:					
DATE OF REPORT					
PROPERTY LOSS/DAMAGE DETAILS					
PROPERTY LOSS/DAMAGE DETAILS **AUTOMATIC TRIP EXTENSION**	DESCRIBTION OF ITEMS	HOUSEHOLD/VALUABLE	AGE OF ITEM	APPROX. VALUE	REMARKS
AUTOMATIC TRIP EXTENSION SCHEDULED DEPARTURE DATE					
	SCHEDULED RETURN DATE	ACTUAL RETURN DATE	DETAILS OF INCIDENT, DATE, PLACE, REASON FOR AUTOMATIC EXTENSION		
EXPENSES CLAIMED DURING EXTENSION					
SR.NO.					
	EXPENSE DETAILS	AMOUNT			
REFUND OF VISA FEE					
REFUND OF VISA FEE COUNTRY WHERE VIDS WAS APPLIED					

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		DATE OF VISA APPLICATION	REASON FOR REJECTION
DOCUMENTS ATTACHED			
DOCUMENTS ATTACHED AMOUNT PAID (VISA FEE)	PROOF OF VISA FEE PAYMENT COPY OF VISA REJECTION LETTER		
ADVENTURE SPORTS CLAIM			
ADVENTURE SPORTS CLAIM TYPE OF SPORT/ACTIVITY			
		DATE &PLACE OF ACTIVITY	DESCRIPTION OF INCIDENT
NATURE OF INJURY/DAMAGE			
NATURE OF INJURY/DAMAGE **EXPENSE DETAILS**		DETAILS OF MEDICAL TREATMENT (IF RECEIVED)	
		AMOUNT CLAIMED	**SUPPORTING DOCUMENTS**
			MEDICAL REPORTS
			HOSPITAL BILLS
			PROOF OF PARTICIPATION IN ADVENTUTRE ACTIVITY
TOTAL CLAIMED AMOUNT:			EXPENSES BILLS/INVOICES
DECLARATION			
DECLARATION I DECLARE THAT TO THE BEST OF MY KNOWLEDGE ALL PARTICULARS IN THIS FORM ARE TRUE. I ALSO AUTHORISE TPA TO OBTAIN ANY MEDICAL RECORDS OR INFORMATION NECESSARY TO PROCESS THE CLAIM			

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I DECLARE THAT TO THE BEST OF MY KNOWLEDGE ALL PARTICULARS IN THIS FORM ARE TRUE. I ALSO AUTHORISE TPA TO OBTAIN ANY MEDICAL RECORDS OR INFORMATION NECESSARY TO PROCESS THE CLAIM PLACE			
PLACE DATE		SIGNATURE OF THE INSURED	