Bajaj Allianz General Insurance Company Limited

GE Plaza, Airport Road, Yerawada, Pune - 411 006.
Tel. : (+91 20) 402 6666. Fax : (+91 20) 402 6667

ACCIDENT AND SICKNESS CLAIM FORM FOR TRAVEL COMPANION

INSTRUCTIONS

1. This form is to be used when filling a claim for reimbursement of Medical Expenses.
2. Section A must be completed by the insured in full.
3. One of the following must be provided
   a. Section B fully completed by the Attending Physician or
   b. Fully itemized bills including : Claimant's Name, Nature of illness / injury, Description and Charge for each service provided.
4. This form must be signed and dated in all applicable sections.
5. This form and all attached bills must be submitted to the address indicated above.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the company, nor a waiver of any of the conditions of the insurance contract.

POLICY NO. ☐☐☐☐☐☐☐☐☐☐ PLAN ____________________

Is International SOS Authorization obtained ? ☐ Yes ☐ No If yes, ISOS Case No. ☐☐☐☐☐☐☐☐☐☐

SECTION A

Coverage Effective Date D D M M Y Y Y Y Coverage Termination Date D D M M Y Y Y Y

Certificate No. (If applicable) ☐☐☐☐☐☐☐☐☐☐

1. Name of Insured ____________________

   Date of Birth D D M M Y Y Y Y Sex : ☐ Male ☐ Female

2. Name of Claimant ____________________

   Claimant's Date of Birth D D M M Y Y Y Y Sex : ☐ Male ☐ Female

3. Current Residence Address ____________________

   Date of Arrival in Country D D M M Y Y Y Y Daytime phone no. ☐☐☐☐☐☐☐☐☐☐

4. Permanent Address (in India) ____________________

   Date scheduled to return to India D D M M Y Y Y Y

5. If Accident, provide details, i.e. how when and where accident occurred :

6. If Sickness, advice when and where symptoms first occured :

7. Name and address of Consulting Physicians(s) :

8. Have you ever been treated for this illness before ☐ Yes ☐ No

If yes, provide name and address of treating Physician(s) and date(s) first consultant

9. Provide Name and Address of your Regular Physician in India

10. Please advice names of any prescription medications you are presently taking

11. Indicate advise Health Insurance coverage, include name, address, policy number and certificate number of Insurer :

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician orother medical professional, pharmary, insurance support organization, governmental agent group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives. any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness 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 authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information . 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.

Signature of Claimant or Parent, If Claimant is a Minor

Date | D | D | M | M | Y | Y | Y | Y |

I hereby certify that the above information is true and correct to the best ofmyknowledge and belief

Signature

Date | D | D | M | M | Y | Y | Y | Y |

ATTENDING PHYCIAN'S STATEMENT

PLEASE ANSWER ALL THE QUESTIONS :

1. Name of the injured person	
2. Age	
3. Address	
4. Nature of the Accident and details of Injury sustained	
5. Does the Cause of Accident as stated by the Claimant	
tally with the injuries noticed by you ?	
6. Are the injuries solely due to the accident or traceable to any previous injuries/disease/infirmities ?	
7. Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition ?	
8. Was the Claimant Hospitalized ? If so for what period ?	
9. What treatment was given and Operations performed ?	
10. Give all dates of treatment : Clinic/Hospital	From D D M M Y Y To D D M M Y Y
Home	From D D M M Y Y To D D M M Y Y
11. Was he under the influence of intoxicants or drugs at the time of accident ?	☐ Yes ☐ No
12. Are you his usual medical attendant ? If you have treated him for any previous illness or Injury, please give details	☐ Yes ☐ No
13. Has other Doctors been in Attendance or Consultation ? If yes, please give details	
14. Has this accident been reported to the Police ? If yes,	Case No Police Station :
15. Is this claimant Totally Disabled from each and every occupation ?	☐ Yes ☐ No
16. (a) How long will the claimant be totally disabled from current occupation ?	From D D M M Y Y To D D M M Y Y
(b) How long will the claimant be partially disabled from current occupation ?	From D D M M Y Y To
17. What is the Prognosis ?	

Doctor's Signature : Date : D D M M Y Y Reg. No.

Doctor's Name :

Address & Phone No. :