RELIANCE General Insurance
Anil Dhirubhai Ambani Group

Reliance Travel Care Insurance Policy

Claim Form

The issue of this form does not constitute admission of liability. Please return the form completed within Fourteen days of the loss together with the relevant vouchers, documents etc.

PLEASE ANSWER EVERY QUESTION FULLY

1. Name of the Insured:					
2. Address of the Insured:	Plot No/Door No.		Building Name		
	Road				
	Area				
	City		Pin code		
	State				
	Phone No.	STD		-	
	Mobile No.				
	E-mail Id				

3. Personal Details
   a) Name of the Insured /Insured person: _____
   (in respect of whom the claim is made)
   b) Present completed age: _____
   c) Occupation: _____

4. Details of Policy:
   a) Policy Number _____
   b) Date of Issue _____
   c) Date of commencement of trip _____
   d) Number of Days _____
   e) Scheduled Date of Return _____
   f) Geographical Limits _____

i) Worldwide Excl USA/CANADA (Please specify the country) _____
ii) Worldwide Incl. USA / CANADA _____

5. Policy Section Relating to Claim:

a) AD & D Common Carrier	☐	k) Medical Expenses	☐
b) Bail Bond	☐	l) Missed Connection	☐
c) Compassionate Visit	☐	m) Personal Accident	☐
d) Daily Allowance in case of Hospitalization	☐	n) Personal Liability	☐
		o) Repatriation of Remains	☐
e) Delay of Checked Baggage	☐	p) Sponsor Protection	☐
f) Dental Treatment	☐	q) Study Interruption	☐
g) Financial Emergency Assistance	☐	r) Total Loss of checked Baggage	☐
h) Hijack Distress Allowance	☐	s) Trip Cancellation & Interruption	☐
i) Home Burglary Insurance	☐		
j) Loss of Passport	☐		

6. Date of injury sustained or disease/illness first detected	☐☐ DD ☐☐ MM ☐☐☐☐ YYYY

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7. Doctor's details
   a) Name & address of the attending medical practitioner _____
   _____
   b) Qualification & telephone no _____
   c) Registration no. _____

8. Name & address of the hospital/nursing home/clinic
   _____
   _____

9. Complaint logged with Service Provider details
   a) Complaint log number _____
   b) Date of complaint ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY
   c) Time of complaint ☐☐ HH ☐☐ MM

d) Whether payment guarantee extended by the Service Provider	☐ Yes ☐ No

e) Hospitalization details:
   a) Date of admission ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY
   b) Date of discharge ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY

f) If the claim is for domiciliary please indicate
   a) Name & address of attending medical practitioner _____
   _____
   _____
   b) Telephone no. _____
   c) Registration no. _____
   d) Date of treatment ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY

g) Schedule of expenses incurred by the claimant under hospitalization/domiciliary (to be supported by bills/receipts, cash memos etc.)

	Expenses incurred in the hospital	**Outside**	**Total**
Hospitalization Benefit			
Domiciliary			

h) Incase of Repatriation of Remains
   a) Cause of Death _____
   b) Date of Death _____
   c) Death Certificate _____

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I have incurred the above expenses for the treatment of the disease / illness / accident referred to here.

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.

Dated at _____ this day of _____ 200 .

Signature of the Claimant