IFFCO-TOKIO GENERAL INSURANCE CO. LTD.
Regd. Office: 34, Nehru Place, New Delhi - 110 019

**ITGI / TP / 07**

# TRAVEL PROTECTOR INSURANCE POLICY CLAIM FORM ( FOR ALL PLANS )

( PLEASE COMPLETE RELEVANT SECTIONS OF THE CLAIM FORM. IF THE SPACE IS INSUFFICIENT PLEASE ATTACH SHEETS TO GIVE FULL INFORMATION )

| | | | | |
|---|---|---|---|---|
| NAME OF THE CLAIMANT (IN FULL) | | POLICY NUMBER | | |
| ADDRESS | | PLAN TYPE | | |
| | | PERIOD OF INSURANCE | FROM | DD/ MM/ YY |
| | | | TO | DD/ MM/ YY |
| OCCUPATION | | DATE TRIP COMMENCED | DD/ MM/ YY | |
| RELATIONSHIP OF THE CLAIMANT WITH THE INSURED PERSON | | DATE OF SCHEDULED RETURN | DD/ MM/ YY | |

**Section to which Claim pertains :** ( PLEASE TICK WHICHEVER ONE IS APPLICABLE )

- ❑ Health Cover:
  - ○ Medical Expenses (Incl. Dental Treatment)
  - ○ Hospital Daily Allowance
  - ○ Transportation
- ❑ Hijack Distress Allowance
- ❑ Loss of Passport
- ❑ Baggage:
  - ○ Total Loss of Checked Baggage
  - ○ Delay of Checked Baggage
- ❑ Financial Emergency Assistance
- ❑ Personal Accident
- ❑ Personal Liability

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 )

A. Medical Expenses ( including dental treatment )

| | | | |
|---|---|---|---|
| NAME OF DISEASE CONTRACTED | | TREATING DOCTOR / CLINIC / HOSPITAL | |
| | | *NAME* | |
| WHEN DISEASE FIRST MANIFESTED | DD/ MM/ YY | *ADDRESS* | |
| DATE WHEN TREATMENT STARTED | DD/ MM/ YY | *CONTACT NUMBER* | |
| DATE WHEN TREATMENT ENDED | DD/ MM/ YY | NATURE OF DISEASE / INJURY ( PLEASE DESCRIBE BRIEFLY ) | |
| DATE OF ADMISSION | DD/ MM/ YY | | |
| DATE OF DISCHARGE | DD/ MM/ YY | | |
| HOSPITAL EXPENSES ( PLEASE SHOW EACH HEAD SEPARATELY ) | | | |
| *ROOM RENT* | | *ROOM RENT IN WORDS* | |
| *CONSULTANCY CHARGES* | | *CONSULTANCY CHARGES IN WORDS* | |
| *COST OF TESTS* | | *COST OF TESTS IN WORDS* | |
| *OTHER COSTS* | | *OTHER COSTS IN WORDS* | |
| OUTPATIENT EXPENSES | | OUTPATIENT EXPENSES IN WORDS | |
| ***TOTAL CLAIM AMOUNT*** | | ***TOTAL CLAIM AMOUNT IN WORDS*** | |

B. Hospital Daily Allowance

| | | | |
|---|---|---|---|
| TOTAL NUMBER OF DAYS FOR AMOUNT BEING CLAIMED FOR | | TOTAL NUMBER OF DAYS FOR AMOUNT BEING CLAIMED FOR IN **WORDS** | |
| ***TOTAL CLAIM AMOUNT*** | | ***TOTAL CLAIM AMOUNT IN WORDS*** | |

C. Transportation

| | | | |
|---|---|---|---|
| IF YOU ARE CLAIMING FOR EXTRA COSTS OF TRANSPORTATION HOME( FOR SELF AND / OR ACCOMPANYING PERSON ), 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*** | | ***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 | DATE OF COMMENCEMENT OF TRAVEL | FLIGHT NUMBER | ROUTE BEING FOLLOWED WHEN HIJACK TOOK PLACE | | | | ARRIVAL TIME | |
| | | | | | | | SCHEDULED | ACTUAL |
| | DD/ MM/ YY | | FROM | | TO | | | |
| ***TOTAL CLAIM AMOUNT*** | | | ***TOTAL CLAIM AMOUNT IN WORDS*** | | | | | |

## FINANCIAL EMERGENCY ASSISTANCE ( Please attach Police Report )

| | | | |
|---|---|---|---|
| AMOUNT OF FUNDS LOST | | PLACE OF LOSS | |
| AMOUNT OF FUNDS LOST IN WORDS | | DATE OF LOSS | DD/ MM/ YY |
| POLICE REPORT LODGED | □ Yes □ No | TIME OF LOSS | |
| ***TOTAL CLAIM AMOUNT*** | | ***TOTAL CLAIM AMOUNT IN WORDS*** | |

## LOSS OF CHECKED BAGGAGE / DELAY OF CHECKED BAGGAGE ( 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** | | | **DELAY OF CHECKED BAGGAGE** | | |
|---|---|---|---|---|---|
| PROPERTY IRREGULARITY REPORT BY CARRIER ATTACHED | □ Yes □ No | | NAME OF THE AIRLINE | | |
| CLAIM LODGED ON CARRIER | □ Yes □ No | | FLIGHT NUMBER | | |
| POLICE REPORT LODGED | □ Yes □ No | | SCHEDULED DEPARTURE | DATE | DD/ MM/ YY |
| | | | | TIME | |
| NUMBER AND DESCRIPTION OF ITEMS LOST | | | SCHEDULED ARRIVAL | DATE | DD/ MM/ YY |
| | | | | TIME | |
| COST OF ITEMS LOST | | | ACTUAL DEPARTURE | DATE | DD/ MM/ YY |
| | | | | TIME | |
| DESCRIPTION OF ITEMS PURCHASED | | | ACTUAL ARRIVAL | DATE | DD/ MM/ YY |
| | | | | TIME | |
| | | | COST OF ITEMS PURCHASED | | |
| ***TOTAL CLAIM AMOUNT*** | | | ***TOTAL CLAIM AMOUNT IN WORDS*** | | |

## LOSS OF PASSPORT ( Please attach Police Report, Proof of Expenditure)

| | | | |
|---|---|---|---|
| DATE OF LOSS | DD/ MM/ YY | POLICE REPORT LODGED | □ Yes □ No |
| APPLICATION / DOCUMENTATION FEES | | INCIDENTAL COSTS | |
| APPLICATION / DOCUMENTATION FEES IN WORDS | | INCIDENTAL COSTS IN WORDS | |
| ***TOTAL CLAIM AMOUNT*** | | ***TOTAL CLAIM AMOUNT IN WORDS*** | |

## PERSONAL ACCIDENT ( Please attach Police Report, Post Mortem Report, Death Certificate, Medical Report )

| | | | | | |
|---|---|---|---|---|---|
| DATE | DD/ MM/ YY | TIME | | PLACE OF ACCIDENT | |
| TREATING DOCTOR / CLINIC / HOSPITAL | | | | POLICE REPORT LODGED | □ Yes □ No |
| NAME | | | | | |
| ADDRESS | | | | FULL DESCRIPTION OF ACCIDENT CAUSE | |
| CONTACT NUMBER | | | | | |
| NATURE OF INJURY SUSTAINED | | | | | |
| | | | | | |
| ***TOTAL CLAIM AMOUNT*** | | | | ***TOTAL CLAIM AMOUNT IN WORDS*** | |

## PERSONAL LIABILITY ( Please attach Judgment of the Court )

| | | | | | |
|---|---|---|---|---|---|
| DATE | DD/ MM/ YY | TIME | | PLACE OF ACCIDENT | |
| NATURE OF CLAIM BEING MADE | | | | COURT WHERE THE CASE IS BEING PURSUED | |
| ***TOTAL AMOUNT OF AWARD INCLUDING CLAIMANT COST*** | | | | ***TOTAL AMOUNT OF AWARD INCLUDING CLAIMANT COST IN WORDS*** | |

## Declaration

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

| | | | |
|---|---|---|---|
| PLACE | | SIGNATURE OF THE INSURED | |
| DATE | DD/ MM/ YY | SIGNATURE OF THE CLAIMANT | |