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ICICI Lombard
Nibhaye Vaade

Smart *Traveller* Insurance Policy (Group) - Claim Form

We would like to inform you that Bharti AXA General Insurance has merged with ICICI Lombard General Insurance w.e.f. Sept 8,2021.
Enjoy our seamless services while exploring our enhanced offerings and diverse non-life insurance solutions

PART I

Important Note

The issue of this form is not to be taken as an admissibility of liability. Please fill this form in **Block Letters** and **Tick the Boxes** ✓ where appropriate and do not leave any column unanswered. If any detail or information is not readily available, please do not delay despatch of this report and such particulars may be sent later.

Master Policy No. 1 2 3 4 5 4 4 0 Master Policy Holder: **Karvat Covermore Assist Pvt Ltd** Claim No.

Period of Insurance: D D M M Y Y Y Y to D D M M Y Y Y Y Certifcate No.

1 Insured Details

(To be filled in block letters)

Name of the Insured

Permanent Address in India

City

Pincode State

Date of Departure D D M M Y Y Y Y Flight No. From To

Date of Return D D M M Y Y Y Y Flight No. From To

Passport No. Date of Birth D D M M Y Y Y Y Gender: ☐ Male ☐ Female

Contact Nos. Mobile No. Office +91

Residence +91 Email ID

2 Claim Details

Type of Claim: ☐ Hospitalization ☐ Medical Expenses ☐ Dental Treatment ☐ Personal Accident ☐ Liability (Personal / Legal)
☐ Repatriation ☐ Loss of Passport ☐ Baggage ☐ Home Contents ☐ Pet Care
☐ Trip Delay / Cancellation ☐ Financial Emergency ☐ Others

3 Hospitalization / Medical & Dental Treatment / Personal Accident / Repatriation

(Please note: The attending physician's report in Part II along with discharge summary & FIR (in case of injury) are essential for claim under this section)

Patient / Claimant Details:

Name

Date of Birth D D M M Y Y Y Y Gender: ☐ Male ☐ Female Relationship with the Insured

Date of Admission D D M M Y Y Y Y Date of Discharge D D M M Y Y Y Y

Name of Hospital where admitted / treated

Address of Hospital

Name of attending Doctor / Physician

Name and address of your family Physician

Illness / Disease:

Nature of Disease / Illness / Diagnosis

Date first noticed / symptoms of Disease / Illness D D M M Y Y Y Y

Have you ever been treated for this Illness / Disease before ☐ Yes ☐ No If yes, provide details

Registered and corporate office address: ICICI Lombard General Insurance Company Ltd., ICICI Lombard House, 414, Veer Savarkar Marg, Prabhadevi, Mumbai – 400025, IRDAI Registration No: 115, CIN:L67200MH2000PLC129408, Telephone: 18001032292, Email Id: customersupportba@icicilombard.com, Product Name: ICICI Lombard Smart Traveller Insurance Policy (Group) - Claim Form.

Injury:

Date of Injury / Accident: D D M M Y Y Y Y

Brief narration of Accident _____

Whether Police report filed? ☐ Yes ☐ No If yes, attach a copy of the report _____

Police station & Report No. _____

If no, please state reasons for not informing Police _____

Are you on any kind of medication prior to Illness / Disease / Injury in question ☐ Yes ☐ No

If yes, provide details _____

Previous claims history under any other existing or expired Travel, Health or Personal Accident Insurances

Sl. No.	Name & Address of Insurance Company	Nature of disease / illness / injury	Policy No.	Date of Claim	Claim Ref. No.	Amount Claimed

Amount of claim (Please mention & include under what head claims are lodged viz. hospitalization, medical, dental treatment etc. and attach separate sheet, if the space is insufficient)

Sl. No.	Description	Bill No.	Date	Amount in Foreign Currency
			Total Amount claimed in INR	

Emergency Evacuation Services Availed ☐ Yes ☐ No If yes, furnish details _____

Compassionate visit done by any Family member ☐ Yes ☐ No If yes, name of the visiting person _____

Relationship with the Insured _____ Date of Travel D D M M Y Y Y Y

4 Loss Of Passport / Emergency Financial Assistance

(Please note: The intimation to Police authority & copy of report is essential for claim under this section)

Passport No. _____ Date of Loss D D M M Y Y Y Y

Brief description of loss _____

Details of Police Report Report No. Date D D M M Y Y Y Y Name of Police Station _____
(Please attach copy)

Details of Expenses Incurred	Date	Place	Amount

5 Delay / Loss of Checked in Baggage

(Please note: The intimation to Airlines, Copy of their PIR & Baggage Tag is essential for claim under this section)

Scheduled Date & Time of Arrival D D M M Y Y Y Y at _____ Hrs at _____ Airport

Actual Date & Time of Arrival of Baggage D D M M Y Y Y Y at _____ Hrs at _____ Airport

Brief description of loss _____

_____ Name of the Airlines _____

Airlines Ref. No. _____ Date & Time when loss was intimated to Airlines _____

Provide the Carrier / Airline details of having given any payment or declined the claim _____

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In case of delay of baggage provide details of emergency purchases made & in case of loss, please provide details of items lost

Sl. No.	Details of Items Lost / Emergency Purchases made	Qty.	Date of Purchase	Purchase Price

Please attach the credit card statement and / or receipts showing emergency purchases made & the correspondence with the airlines.

6 Trip Delay / Cancellation / Hijack / Missed Connection / Overbooked Flight or Emergency Accommodation

(Please note: The documentary evidences regarding delay / cancellation etc. is mandatory for claim under this section)

Flight Details _____

Scheduled Date & Time of Departure D D M M Y Y Y Y at ____ Hrs.

Actual Date & Time of Departure D D M M Y Y Y Y at ____ Hrs.

Reason for the Delay / Cancellation of the Trip _____

Details of Financial Losses / Additional Expenses due to Delay / Cancellation of Trip or Emergency Accommodation

Sl. No.	Description	Amount

Was the Accommodation / Boarding / any kind of Compensation provided by Carrier / Airlines ☐ Yes ☐ No

If yes, please provide the details

7 Home Contents / Fire / Burglary / Pet Care

Date of Loss D D M M Y Y Y Y

Brief description of Loss _____

Details of Loss (Please attach relevant supporting documents)

Sl. No.	Description	Amount

8 Liability (Personal / Legal) or Any other type of Claim

(Please note: The documentary evidences regarding accident / police report / legal reports etc. are mandatory for claim under this section)

Date of Accident D D M M Y Y Y Y

Brief description of Accident _____

Details of Liability / Status of Legal Case _____

9 Other Insurance Details

Are you currently insured under any other Travel, Health, Home or Baggage Insurance policies? ☐ Yes ☐ No If yes, provide details

Sl. No.	Name & Address of Insurance Company	Policy No.	From	To	Sum Insured (Rs.)

Do you wish to provide any other information as relevant to the claim made? ☐ Yes ☐ No If yes, details (if required you may attach a separate sheet) _____

10 Consent for Access to Records & Declaration

I/We hereby authorize ICICI Lombard General Insurance Co. Ltd. or any other individual/agency engaged by ICICI Lombard to obtain all medical or legal record pertaining to the above patient/insured available with any hospital/doctor/legal forum.

I/We agree to provide additional information to the Company, if required. I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and if I/We have made, or in any further declaration the Company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, the policy shall be void and all rights to recover there under in respect of past or future claims shall be forfeited.

Date D D M M Y Y Y Y Place _____

Signature of the Insured

Registered and corporate office address: ICICI Lombard General Insurance Company Ltd., ICICI Lombard House, 414, Veer Savarkar Marg, Prabhadevi, Mumbai – 400025, IRDAI Registration No: 115, CIN:L67200MH2000PLC129408, Telephone: 18001032292, Email Id: customersupportba@icicilombard.com, Product Name: ICICI Lombard Smart Traveller Insurance Policy (Group) - Claim Form.

Attending Physician's Statement

Name of the Patient _____

Age in Years ☐☐ Gender: ☐ Male ☐ Female

Address _____

_____ City _____

Pincode _____ State _____

Illness / Disease Cases

Date when patient approached for first consultation / treatment D D M M Y Y Y Y

Diagnosis _____

Please provide previous Medical history of the Patient _____

Is the present condition attributed to congenital defect? If yes, please provide details _____

Injury Cases

Nature of the accident & details of injuries sustained _____

Are the injuries solely due to the accident or traceable to any previous injuries / disease / infirmities? _____

Nature of treatment / surgery performed for present illness / disease / injury _____

Has the injury resulted in to any Permanent Total / Partial Disablement? ☐ Yes ☐ No

If yes, please provide details _____

Was the patient under the influence of intoxicants or drugs at the time of the accident? ☐ Yes ☐ No

If yes, please provide details of diagnosis done _____

Are you patient's usual Medical Attendant? ☐ Yes ☐ No

If yes, please give details of previous treatments for any illness / disease / injury _____

Doctor's Name _____

Registration No. _____

Addresss _____

Telephone No. _____

Date D D M M Y Y Y Y

Doctor's Name & Address Stamp

Signature of the Doctor

CLAIM FORM/TRAVEL/THINQ/09-14. Insurance is the subject matter of solicitation.