Universal Sompo General Insurance Co. Ltd.

For Claim Assistance please call at our toll free no.1800224030 or email us at contactclaims@universalsompo.com

OVERSEAS TRAVEL INSURANCE POLICY CLAIM FORM (FOR ALL PLANS)

(The issuance of this form does not imply admission of liability)

POLICY NUMBER		PERIOD OF INSURANCE	Form	DD/ MM/ YY
PLAN TYPE			To	DD/ MM/ YY
NAME OF THE CLAIMANT (IN FULL)				
ADDRESS				
CONTACT DETAILS	Tel / Reg Off		Mobile	
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
  - ➢ Medical Repatriation
  - ➢ Repatriation of mortal remains
- ☐ Loss of Passport
- ☐ Personal Liability
- ☐ Baggage:
  - ➢ Total Loss of Checked Baggage
  - ➢ Delay of Checked Baggage
- ☐ Financial Emergency Assistance
- ☐ Personal Accident
- ☐ Hijack Distress Allowance

ALL CLAIMS HAVE TO BE SUPPORTED WITH ORIGINAL DOCUMENTS OF EXPENSES / COSTS INCURRED AS APPLICABLE

Section I - HEALTH COVER

(Please attach original Doctor's Certificate, Test Reports and Hospital Papers including Discharge Card Final Hospital Bill And Receipts as Applicable)

A. Medical Expenses (including dental treatment)

WHEN DISEASE FIRST MANIFESTED	DD/ MM/ YYYY	TREATING DOCTOR / CLINIC / HOSPITAL	
		NAME	
NATURE OF DISEASE / INJURY (PLEASE DESCRIBE BRIEFLY)		ADDRESS	
DATE WHEN TREATMENT STARTED	DD/ MM/ YYYY	COUNTRY	
DATE WHEN TREATMENT ENDED	DD/ MM/ YYYY	CONTACT NUMBER	
DATE OF ADMISSION	DD/ MM/ YYYY	DATE OF DISCHARGE	DD/ MM/ YYYY
HOSPITAL EXPENSES (PLEASE SHOW EACH HEAD SEPARATELY)			
INPATIENT EXPENSES		OUTPATIENT EXPENSES	
DENTAL EXPENSES		TOTAL CLAIM AMOUNT	

B.Repatriation

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	

C. Balance period of Policy + 30days

TREATING DOCTOR / CLINIC / HOSPITAL IN INDIA			
NAME			
ADDRESS			
CONTACT NUMBER			
NATURE OF DISEASE / INJURY (PLEASE DESCRIBE BRIEFLY)			
DATE OF ARRIVAL IN INDIA	DD/ MM/ YYYY	DATE OF ADMISSION	DD/ MM/ YYYY
DATE OF DISCHARGE	DD/ MM/ YYYY	TOTAL CLAIM AMOUNT	

D.Hospital Daily Allowance

TOTAL NUMBER OF DAYS FOR AMOUNT BEING CLAIMED FOR		TOTAL CLAIM AMOUNT	

Section II - 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		
NAME OF THE AIRLINE				
FLIGHT NUMBER		FROM		
PROPERTY IRREGULARITY REPORT BY CARRIER ATTACHED	☐ Yes ☐ No	TO		
		SCHEDULE D DEPARTUR	DATE	DD/ MM / YYYY
			TIME	
CLAIM LODGED ON CARRIER	☐ Yes ☐ No	SCHEDULE D ARRIVAL	DATE	DD/ MM / YYYY
			TIME	
POLICE REPORT LODGED	☐ Yes ☐ No	ACTUAL DEPARTUR	DATE	DD/ MM / YYYY
			TIME	
		ACTUAL ARRIVAL	DATE	DD/ MM / YYYY
			TIME	
NUMBER AND DESCRIPTION OF ITEMS LOST/PURCHASED		COST OF ITEMS LOST		
		COST OF ITEMS PURCHASED		
TOTAL CLAIM AMOUNT				

Section III – HIJACK DISTRESS ALLOWANCE

(Please attach police report confirming the incident and mentioning the Insured's passport number and period of hijack)

NAME OF CARRIER		CARRIER FLIGHT NUMBER	
PORT OF HIJACK		PORT OF RELEASE	
DATE AND TIME OF HIJACK	From: DD/ MM / YYYY At: 00:00 Hr	To: DD/ MM / YYYY	At 00:00 Hr

Section IV - LOSS OF PASSPORT

(Please attach Police Report, Proof of Expenditure)

DATE OF LOSS	DD/ MM / YYYY	POLICE REPORT LODGED	☐ Yes ☐ No
APPLICATION / DOCUMENTATION FEES		INCIDENTAL COSTS	
TOTAL CLAIM AMOUNT			

Section V - FINANCIAL EMERGENCY ASSISTANCE

(Please attach Police Report)

AMOUNT OF FUNDS LOST		PLACE OF LOSS	
DATE OF LOSS	DD/ MM / YYYY	TIME OF LOSS	
POLICE REPORT LODGED	☐ Yes ☐ No	TOTAL CLAIM AMOUNT	

Section VI - PERSONAL LIABILITY

(Please attach Judgment of the Court)

DATE	DD/ MM / YYYY	TIME		PLACE OF ACCIDENT	
NATURE OF CLAIM BEING MADE					
COURT WHERE THE CASE IS BEING PURSUED				TOTAL AMOUNT OF AWARD INCLUDING CLAIMANT COST	

Section VII - PERSONAL ACCIDENT

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

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

Section VIII/IX/X – TRIP DELAY/ TRIP CANCELLATION/ MISSED CONNECTION

(Please attach Medical reports, Discharge card/Death certificate for Medical reason; letter from Airlines for Hijack/Quarantine; and more sheets to give Expense details wherever necessary)

TRIP DELAY			TRIP CANCELLATION		MISSED CONNECTION
NAME OF THE AIRLINE					
FLIGHT NUMBER			FROM		
NO OF HOURS DELAYED			TO		
SCHEDULED DEPARTURE	DATE	DD / MM / YYYY	ACTUAL DEPARTURE	DATE	DD / MM / YYYY
	TIME	00:00		TIME	00:00
SCHEDULED ARRIVAL	DATE	DD / MM / YYYY	ACTUAL ARRIVAL	DATE	DD / MM / YYYY
	TIME	00:00		TIME	00:00
DEPARTURE OF CONNECTING FLIGHT	DATE	DD / MM / YYYY	CAUSE OF DELAY		
	TIME	00:00			
RELEVANT CERTIFICATE PROVIDED BY AIRLINES			□ Yes □ No		

REASON FOR TRIP CANCELLATION	ILLNESS OR INJURY □	DEATH □	PERSON AFFECTED	INSURED □	SPOUSE □	
	QUARANTINE □	HIJACK □		CHILD □	PARENT □	
NAME OF AFFECTED PERSON						
ADDRESS OF AFFECTED PERSON						
DETAILS OF THE REASON FOR TRIP CANCELLATION						

DETAILS OF EXPENSES IN CASE OF TRIP DELAY /CANCELLATION

SR NO	EXPENSE DETAIL	CONTRACTED/PAID	AMOUNT REFUNDED	NET LOSS	PAYMENT RECEIPTS	REFUND/NO REFUND LETTER
TOTAL CLAIM AMOUNT						

Section XI – BURGLARY (HOME CONTENTS)

(Please attach FIR, Investigation report by Local Police, Invoices of owned articles and more sheets to give Estimated loss details wherever necessary)

ADDRESS OF PROPERTY WHERE LOSS WAS SUSTAINED			
	CITY:	STATE:	PIN CODE:
DATE OF LOSS	DD / MM / YYYY	LOSS DISCOVERED BY	
CONTENTS OF HOME	LOSS:	DAMAGE:	BOTH:
DETAILED CIRCUMSTANCES OF THE LOSS			
REPORT LODGED WITH POLICE	□ Yes □ No	IF REPORTED, BY WHOM	
REASON FOR NOT REPORTING			

SR NO	LOSS DETAILS	LOSS/DAMAGE	ESTIMATED COST OF LOSS
DETAILS OF ANY OTHER INSURANCE TO COVER FOR THE PROPERTY			

Section XII/XIII – STUDY INTERRUPTION/ACCIDENT TO SPONSOR

(Please attach Medical reports, Discharge card/Death certificate, Tuition fee invoices, Bills, Receipts and more sheets to give Expense details wherever necessary)

DUE TO	☐ HOSPITALIZATION OF INSURED	☐ DEATH OF FAMILY MEMBER	☐ DEATH OF SPONSOR			
NAME OF AFFECTED PERSON						
ADDRESS OF AFFECTED PERSON						
DATE OF LOSS	DD/ MM/ YYYY	LOSS DISCOVERED BY				
DATE OF HOSPITALISATION	FROM: DD/ MM/ YYYY	TO: DD/ MM/ YYYY	DATE OF DEATH	DD/ MM/ YYYY		
CIRCUMSTANCES LEADING TO THE LOSS		TREATING DOCTOR / CLINIC / HOSPITAL				
		NAME				
		ADDRESS				
		CONTACT NUMBER	Res Off			
REASON FOR DISCONTINUING STUDIES ABROAD			Mobile			
DETAILS OF TUITION FEES						
SR NO	EXPENSE DETAILS	AMOUNT CONTRACTED/PAID	AMOUNT REFUNDED	NET LOSS	PAYMENT RECEIPTS	REFUND/NO REFUND LETTER

Section XIV – COMPASSIONATE VISIT

(Please attach Medical reports; Discharge card/Death certificate; Doctor's statement specifically stating the need for an attendant and forbiddance for repatriation; and more sheets to give loss details wherever necessary)

PERSON HOSPITALISED	☐ INSURED	☐ PARENT	☐ SPOUSE	☐ CHILD	
NAME OF PERSON HOSPITALISED					
DATE OF HOSPITALISATION	DD/ MM/ YYYY	ESTIMATED LENGTH OF STAY IN DAYS AS PER TREATING DOCTOR			
DATE OF ONSET OF AILMENT	DD/ MM/ YYYY	TREATING DOCTOR / CLINIC / HOSPITAL			
		NAME			
DETAILS OF AILMENT NECESITATING HOSPTALISATION NAME		ADDRESS			
		CONTACT NUMBER	Res Off		
			Mobile		
CAUSE OF AILMENT	Treating doctors opinion for forbidding repatriation of Insured				
PLEASE EXPLAIN IN DETAIL WHETHER THE AILMENT/INCIDENCE CAUSED/AGGRAVATED DUE TO A PRE EXISTING CONDITION					
TREATMENT DETAIL	STREATING DOCTOR'S OPINION ON NEED FOR ATTENDANT				

Declaration

I/We hereby to the best of my/our knowledge and belief, warrant the truth of the above details in every respect I/We agree that if we have made already or if I/We make in any of my/our further statements in respect of the said incident or any false or fraudulent declarations or suppress or conceal any material fact, the Policy shall be void and all rights of compensation in respect the present or future claim shall be forfeited.

Place:

Date: Signature of Claimant/Insured

Universal Sompo General Insurance Co. Ltd.

Unit 401, 4th Floor, Sangam Complex, 127Andheri-Kurla Road, Andheri (E), Mumbai – 400059.

Tel.: 18001024030, 1800224030, 18002004030, 022-29211800

toll free no.1800224030

Email:contactclaims@universalsompo.com

(A JOINT VENTURE BETWEEN Allahabad Bank Indian Overseas Bank Karnataka Bank Dabur Investment Sompo Japan Insurance Inc. of Japan)

Universal Sompo General Insurance Co. Ltd.

(A joint venture between Allahabad Bank, Sompo Japan Insurance Inc., Indian Overseas Bank, Karnataka Bank and Dabur Investments)

Regd. Office : Unit No. 401, 4th Floor, Sangam Complex, 127 Andheri Kurla Road, Andheri (East), Mumbai-400059

Bank Account Mandate for Direct Credit

(This form to be used for one time Customer payment only)

For legibility, please use BLOCK LETTERS in black ink.

Universal Sompo Location: _____ **Claim no:** _____ **Date:** _____

Beneficiary Details (TO BE FILLED IN - BLOCK LETTERS ONLY) *all fields are mandatory*

Beneficiary Name : _____
(Should be same as in Bank) First Name Middle Name Last Name

Address : _____
(As per the policy)
: _____

City : _____ **Pin Code:** _____

PAN No : _____ **Date of Birth:** ____/____/____DD MM YYYY

Service Tax Reg No: _____ **E Mail:** _____

Phone No.(with STD code): _____ **Mobile Number :** _____

Bank Account Details (TO BE FILLED IN - BLOCK LETTERS ONLY) *all fields are mandatory as per bank records*

Bank Account Number : _____ **Account Type:** _____(Savings /Current/Other etc)

Name of the Bank : _____

Bank Branch Name : _____ **Bank Branch Code:** _____

IFSC Code : _____ **MICR Code:** _____

(The above details are available on the face of the cheque ***as per CTS-2010/06.2013***. If not, please speak to your branch and get the details / submit the copy of bank pass book where all the above details are available)

*** I /we DO NOT wish to receive direct credits, but wish to receive payment by cheque. (Please ✓)** ☐

I hereby understand and confirm that:

1) The details given above are true and I have no objection for directly credits in the bank account mentioned above.
2) If the electronic credit is not effected, delayed or credited to a wrong account on account of incorrect or incomplete information provided, USGIC shall not be held liable now or in future for such losses.
3) In the event the credit is not effected by your Banker for any reason, USGIC reserves the right to make the payment through cheque. USGIC shall not make any payout either partially or wholly in the form of cash.
4) Enclosed copy of PAN OR certificate of Service Tax registration (if applicable for institutions).
5) Enclosed cancelled cheque as per CTS-2010 of the bank account mentioned above.
6) If wise to receive payments by cheque instead of direct credit, have appropriately ticked the check –box provided for this purpose.

Place: _____ _____

Date: D D M M Y Y Y Y Signature of Customer

Documents to be attached:

- Self attested copy of PAN Card **OR** Service Tax Regn certificate (if applicable for Institutions)
- Original cancelled Cheque (CTS- 2010) duly signed by insured

Inward stamp with date

Verified by Company :YES / NO

Signature of Verifying Person: _____ **Date: D D M M Y Y Y Y**