Royal Sundaram

OVERSEAS TRAVEL ACCIDENT AND SICKNESS CLAIM FORM

FOR OFFICE USE ONLY

Issuing office :_____

Date of Issue :_____

Claim Number:_____

ROYAL SUNDARAM ALLIANCE INSURANCE COMPANY LIMITED

46, Whites Road, Chennai-600 014. Telephone : 044-28517387 - 7391 Fax: 044-2851 5500

E-mail : customer.services@royalsundaram.in

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

Please ensure that all questions are answered in Capital Letters using an ink pen

Policy Number		Travel Shield Gold / Travel Shield Extra / Travel Shield Plus (Please strike out whichever is not applicable)	
Name of the Insured			
Name of the Claimant			
Current Residential Address (overseas)		Permanent Address (In India)	
Telephone Number (ISD)		Telephone Number (STD)	
E-mail Address		Mobile Number	
Date of commencement of Trip		Scheduled / Actual date of return to India	
Was International SOS Authorisation obtained before hospitalisation?	Yes ☐ No ☐	If 'Yes', International SOS Case No.	

PLEASE FILL THIS COLUMN IF YOU HAVE OPTED TRAVEL SHIELD PLUS POLICY

Have you undertaken any journey overseas after the commencement of this policy? Yes ☐ No ☐

If 'Yes' please state the total number of days on each tour	Places visited	Number of days

Nature of Claim **(Please fill in the appropriate section (a) or (b) as applicable)**

a) Accident

How did the accident occur?	
When and where did the accident occur?	

b) Sickness

Nature of illness

When and where did the symptoms first occur?

Date of Admission to Hospital / /

Date of Discharge / /

Name and address of the Consulting Physician

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

If 'Yes', Name and address of your regular physician in India

Details of expenses incurred

Sl. No.	Bill Number	Date	Description of expenses	Amount

Declaration

I hereby declare that the foregoing statements made are true and correct to the best of my knowledge and I have not attempted to conceal anything of material importance. I agree that if I have made, or will make any false or fraudulent statement whatsoever, the policy shall be void and my right to compensation forfeited.

Date: / /

Signature or thumb impression of the Insured

Authorisation

I, the undersigned authorise any hospital, medical-care institution, physician or other medical professional, pharmacy to provide any and all medical information in respect of which consultation was made and treatment given, to the Insurance Company or its representatives.

Date: / /

Signature or thumb impression of the Insured

TO BE FILLED IN BY THE MEDICAL PRACTITIONER

Patient Identity Number (Inpatient or Outpatient Number)

Patient Name

If the Injury was sustained by an accident, please describe

Nature and cause of accident

Extent of injury sustained

Was he/she to your knowledge under the influence of Intoxicants or drugs at the time of accident Yes ☐ No ☐

If the treatment given is for illness/sickness/disease, please furnish

Diagnosis or nature of illness

How long in your opinion could this ailment be existing? (Sign of first symptom appearing)

If admitted in a hospital,

Name and address of the hospital

Date of Admission (DD/MM/YY)

Date of Discharge (DD/MM/YY)

Nature of Treatment given

Does the illness/sickness warrant the treatment given Yes ☐ No ☐

Present condition

Nature of Disablement

Extent of Disablement Permanent Total / Permanent Partial

Percentage of Disablement

Any other remarks you wish to make

I hereby certify that the details given are true and correct to the best of my knowledge.

Name of Doctor

Qualification & Credentials

Address

Signature of the Doctor

Additional Information :