IFFCO-TOKIO GENERAL INSURANCE CO. LTD

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi-110017

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	