CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED

Registered and Head Office:" Dare House" 2nd Floor, No.2, N.S.C. Bose Road, Chennai 600 001 customercare@cholams.murugappa.com; Toll free help line 1800 200 5544; www.cholainsurance.com



General Insurance

Leisure Travel Insurance - Claim Form

• The issuance of this form is not to be taken as an Admission of Liability. • Please answer all questions completely. Use additional sheet, if required. • Please attach the document required as indicated. • Please note that the list of documents mentioned is an indicative list; the Insurer may ask for any other documents to process the claim. • Please attach the medical report in the enclosed format for claim under Personal Accident.

A. Details of The claimant:	Name of Claimant (i	in full)	Mr. Mrs.	Ms Dr	Prof M/s
Policy Number			Period of II	nsurance DDMM	2 0 0 Y To D D M M 2 0 0 Y
Address					
City		Pin code	State		
Tel. No.	Fax No.			Mobile No.	
Occupation			E-mail		
Relationship of claimant with the insured		ate of commencement o	f Trip DDDMM2	2 0 0 Y Date of Sci	neduled Return DDDMM2000Y
Country visited			Curre	ncy of the country	
Section to which Claim pertains	S (Please tick whichever is an	oplicable)		, , ,	
•	Repatriation of Remains	Dental Treatment	Expenses	Total Loss of Chec	ked Baggage
Delay of Checked-In Baggage	oss of Passport	Loss of Internatio	nal Driving License	Personal Accident	– Overseas
	Financial Emergency	Hospital Daily cas	h	Hijack Relief	
Trip Cancellation	Trip Curtailment	Trip delay		Personal Accident	Domestic Home Burglary
B. Medical Expenses — Please atta of passport / visa with entry & exit stam			card, Original bills / re	ceipts / with prescription	s and diagnostic /investigative reports, Copy
Name of disease contacted					
When disease first manifested	D D M M 2 0 0 Y Da	ate when treatment star	ted DDMM2	2 0 0 Y Date when tre	eatment ended DDMM2000Y
Date of admission		ate of discharge	D D M M 2		
Name of treating doctor / clinic / hospita					
Address		(1)	" (' ")		
Contact number	Nature of Dise	ease/Injury <i>(Please des</i>	cribe briefly)		
Hospital expenses (Please show each he	ad separately: Please mentic	on in US Dollars)			
Room rent	Consultancy Charges		ost of treatment		
Other costs	Outpatient expenses		ost of tests		Total claim amount
Transportation Expenses : If you are cla following details		transportation home (f	or self and / or accom	panying person), mortal	remains or burial expenses, please provide
Name of airlines		В	urial Details		
Expenses incurred	Other incide	ntal costs with bifurcat	on of expenses		
C. Dental Treatment Expenses reports, Copy of passport / visa with ent				ginal bills / receipts / wit	h prescriptions and diagnostic /investigative
Name of the disease contacted					
When disease first manifested (Date)	D D M M 2 0 0 Y	Date when treatment	started DDMM2	Date when	treatment ended DDMMM2000Y
Date of admission	D D M M 2 0 0 Y	Date of discharge	D D M M 2		
Name of treating doctor / clinic / hospita	'				
Address					
Contact number	Nature of Dise	ease/Injury <i>(Please des</i>	cribe briefly)		
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Other costs	Consultancy Charges	(net of tasts		Total claim amount
Other costs	Outpatient expenses		lost of tests	and purchase data. Capi	Total claim amount
D. Total Loss of Checked-In Bag with airline authorities / others about loss from airline), Copy of the passport / vis equivalent of US \$ 100 for loss/delay of	Outpatient expenses	etails of individual items with details of compensa Adequate proof of own	lost, approximate cost ation received from airli	ines / other authorities (i	Total claim amount
D. Total Loss of Checked-In Bag with airline authorities / others about loss from airline), Copy of the passport / vis	Outpatient expenses	etails of individual items with details of compensa Adequate proof of own	lost, approximate cost ation received from airli	ines / other authorities (i	es of baggage tags, Copies of correspondence f any), Property Irregularity Report (obtained
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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: