ICICI Lombard
Nibhaye Vaade

Overseas Travel Insurance Claim Form

Guidelines for completion of the Claims form

1. Claims Form consists of two parts - Information Sheet and Coverage
2. Please fill the Information Sheet along with the relevant annexure as per the desired coverage.
3. Please take the print out of only the relevant annexure.

In the event of a claim, contact our below 24 -hour helpline numbers	
In USA	+1 877 352 7706 (Toll Free)
In Canada	+1 877 352 7706 (Toll Free)
In India	1800 2666 (Toll Free & Accessible in India only)
	+91 92236 22666 (Chargeable)
From the rest of the world	+91 22 6787 2010 (Call Back Facility)
Fax	+91 22 6734 7888
E-mail	icicilombard@europ-assistance.in
Claim Processing Department Address	ICICI Lombard General Insurance Company Limited, C/O Europ Assistance India Pvt Ltd. 301, C Wing, Business Squaree, Andheri Kurla Road, Chakala, Andheri (E), Mumbai - 400 093, India

INFORMATION SHEET

INSURED DETAILS

Policy No.:

Policy Start Date: D D/ M M/ Y Y Y Y Policy End Date: D D/ M M/ Y Y Y Y

(First) (Middle) (Last)

Full Name:

Date of Birth: D D/ M M/ Y Y Y Y Sex: Male ☐ Female ☐

Current Address:

Address in Country of Residence:

Phone No. Overseas: Phone No. India:

Mobile No: Email ID:

Passport No.: Claims Ref No.:(As provided)

Every claim has to be accompanied with original ticket/ boarding pass or copy of the passport indicating the travel dates.

CLAIMANT INFORMATION (If different than "Insured Information" above)

Full Name:

Date of Birth: D D/ M M/ Y Y Y Y Sex: Male ☐ Female ☐ Relationship with the Policyholder:

Claimant's Address:

Phone No. (Off): Phone No. (Res):

Email ID:

In what capacity are you making this claim?

Terms and conditions

1. The Insured shall ensure that the Insured has received, read and understood the terms and conditions as contained in Part II and III of the Policy. If the Insured has not received Part II and Part III of the Policy, please email at customersupport@icicilombard.com.
2. In the event of an Accident or sudden Illness or occurrence of any other contingency covered under the Policy, the Insured shall immediately contact the Help Line number and register his/ her claim furnishing the necessary details.
3. Failure of immediate intimation to the helpline may result in the Insured's claim being prejudiced and in no case being admitted for more than 75% of the claim. No expenses however beyond a limit of US$ 1000 shall be incurred by the Insured without prior approval from the Company.
4. This condition shall be applicable even in cases where the Insured would like to pursue his claim only on his return to his place of residence in spite of his meeting with the contingency covered herein whilst abroad.
5. Please note, Deductible amount as mentioned in Policy Schedule must be borne by you.
6. Issuance of the claims form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract.
7. No claim under Accident & Medical Section will be admitted without Doctor's Report as per format.
8. Please answer all questions completely. In case of insufficient space, please attach additional sheets.
9. Please attach original of all bills, receipts, credit card slips pertaining to your claim. Every claim has to be accompanied with original ticket/ boarding pass or copy of passport indicating the travel dates.

DECLARATION

I/We hereby agree, affirm and declare that:

1. The statements/ information given/ stated by me/ us in this claim form are true, correct and complete.
2. The details of all persons having an interest in the property in respect of which the claim is being made are provided as per the proposal form or by way of an endorsement in the policy. Furthermore, save and except as provided or disclosed in this claim form, no claim made hereunder (or the same/ similar claim) has been made or lodged with any other insurance company.
3. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.
4. If I/ We have given/ made any false or fraudulent statement/ information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I/ We shall not be entitled to all/any rights to recover thereunder in respect of any or all claims, past, present or future.
5. The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information and documents in respect of the claim.
6. I do hereby authorize International Subrogation Management (ISM) to inquire and obtain any information regarding my accident. Further, ICICI Lombard is hereby authorized to release any and all information, including copies of pertinent documents, which ISM may deem necessary in order to satisfy their inquiry, If during the investigation, ISM has identified a potential recovery source, allowing the Plan Participant's employer to recover paid benefits, ISM is authorized to release any all records they deem necessary in order to pursue the recovery.
7. The company can, while assessing the claim, call for the additional documents which the Company deems fit for assessment of the claim.

Dated: D D/ M M/ Y Y Y Y Place:

Claimant's/ Insured's Signature

AUTHORIZATION BY INSURED/ ON BEHALF OF THE INSURED

1. I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the Insured to release any information requested regarding this claim and the loss reported.
2. I understand ICICI Lombard General Insurance Company Ltd, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim, will use this information.
3. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original.
4. I agree that this authorization shall be valid for the duration of this claim. I also authorize Assistance Service Provider, on behalf of ICICI Lombard General Insurance Company Limited, to obtain any medical records or information to process this claim.
5. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Claimant or authorized person)

Relationship with the Insured

Dated: D D/ M M/ Y Y Y Y Place:

Insured's Signature

Annexure 1: MEDICAL COVER & DENTAL TREATMENT

OUT PATIENT TREATMENT

Nature of Ailment: _____

State Diagnosis and nature of treatment taken: _____

Dates of treatment: From D D/ M M/ Y Y Y Y To: D D/ M M/ Y Y Y Y Date of onset of symptoms: D D/ M M/ Y Y Y Y

Name, address & telephone number of consulting physician/ dentist/ hospital where treatment was taken: _____

_____

Have you ever been treated for this illness before: Yes ☐ No ☐ If yes, provide name, address & telephone number of consulted physician: _____

_____

Provide name, address & telephone number of your family/ regular doctor in India: _____

_____

Provide name of any prescription medicine you are presently taking: _____

_____

Hospitalisation

Full Name: (First) _____ (Middle) _____ (Last) _____

Address: _____

Phone Number of Hospital/ Clinic: _____ Treating Doctor's Name & Qualifications: _____

Treating Doctor's Telephone Number: _____ (M) _____

Dates of Treatment: From: D D/ M M/ Y Y Y Y To: D D/ M M/ Y Y Y Y Date of onset of Symptoms: D D/ M M/ Y Y Y Y

Attending Doctor's Report

Date Doctor Contacted: D D/ M M/ Y Y Y Y Time: H H: M M Nature of Ailment: _____

State diagnosis and nature of treatment provided: _____

When did patient's symptoms first appear? D D/ M M/ Y Y Y Y

Describe any other disease or infirmity affecting present condition: _____

Was the ailment due to Pregnancy: Yes ☐ No ☐

Was the ailment aggravated due to any pre-existing condition? Yes ☐ No ☐ If yes, please give details: _____

Can the patient be evacuated back to the Republic of India? Yes ☐ No ☐

Is Medical Evacuation back to Republic of India needed? Please give detailed reasons of the ailment and reason for transportation: _____

_____

_____

MEDICAL TREATMENT EXPENSES DETAILS

Sr. No.	Details of treatment/ expenses	Date	Expenses in Foreign Currency
Total:			

Claiming also for daily allowance

Documents to be submitted in support of the claim:

1. Medical reports and discharge summary issued by the Hospital furnishing the name of the Insured, period of treatment, details of treatment rendered.
2. Bills/ receipts for:
   a. Charges paid towards Hospital accommodation, nursing facilities and other medical services rendered
   b. Fees paid to the Medical Practitioner, special nursing charges, etc.
   c. Charges incurred towards any and all test and/ or examinations rendered in connection with the treatment.
   d. Charges incurred towards medicines or drugs purchased from outside duly supported by the prescriptions of the Medical Practitioner attending on the Insured.

In respect of all claims payable hereunder, the Company may effect settlement either in the form of cashless treatment facility or by reimbursement of the amount of claim to the Insured, at its sole discretion. Cashless treatment facility cannot be demanded by the Insured as a matter of right.

Dated: D D/ M M/ Y Y Y Y Place: _____

_____
Claimant's/ Insured's Signature

Annexure 2: REPATRIATION OF REMAINS

Cause/ Circumstances of death: _____

Date of death of Insured: D D/ M M/ Y Y Y Y

Details of expenses incurred for repatriation of Remains/ Funeral:

Sr. No.	Details of expenses	Date	Expenses in Foreign Currency
		D D/ M M/ Y Y Y Y	
		D D/ M M/ Y Y Y Y	
		D D/ M M/ Y Y Y Y	
		D D/ M M/ Y Y Y Y	
		D D/ M M/ Y Y Y Y	
Total:			

Documents to be submitted in support of the claim:

1. Photocopy of the death certificate providing the details of the place, date and time, and the circumstances and cause of the death (photocopy of the postmortem certificate wherever required by the Assistance Service Provider), issued by the appropriate authority where the contingency has arisen.
2. Proof for expenses incurred towards disposal of the mortal remains.
3. In case of transportation of the body of the deceased to the Country of Residence of the Insured, the receipt for expenses incurred towards preparation and packing of the mortal remains of the deceased and also for the air transportation of the mortal remains of the deceased to the Country of Residence of the Insured.

Dated: D D/ M M/ Y Y Y Y Place: _____

_____
Claimant's/ Insured's Signature

Annexure 3: CHECKED-IN BAGGAGE LOSS/ DELAY

Describe when & where the Loss/ Delay took place: _____

State the extent of Delay/ Loss: _____

Name the common carrier: _____

Flight Details:

1. Flight No.: _____ From D D/ M M/ Y Y Y Y To: D D/ M M/ Y Y Y Y

2. Flight No.: _____ From D D/ M M/ Y Y Y Y To: D D/ M M/ Y Y Y Y

Port of Delay/ Loss: _____

Actual Date & Time of Arrival of flight at Port: D D/ M M/ Y Y Y Y H H: M M

Actual Date & Time when Bags were delivered: D D/ M M/ Y Y Y Y H H: M M

No. of Hours of bag delay: _____ Had the common carrier been notified at the time of loss? Yes ☐ No ☐

Details of compensation received from carrier: _____

Sr. No.	Item Purchased/ Items Lost	Date of Purchase	Cost in Foreign Currency (In INR for loss claim)
Total:			
Compensation From Airlines:			
Net Amount:			

Documents to be submitted in support of the claim for Checked-in Baggage Loss:

1. Statement of claim furnishing the details of items contained in the Checked-In Baggage and the values thereof (excluding Valuables). Values of the items shall represent their market value after allowing for age and usage.
2. Property irregularity report issued by the Common Carrier.
3. Voucher of the Common Carrier for the compensation paid for the non-delivery/ short delivery of the Checked-In Baggage.
4. Copies of correspondence exchanged, if any, with the Common Carrier in connection with the non-delivery/ short delivery of the Checked-In Baggage.
5. In case of items of individual value equal to or more than US$ 100 contained within the Checked-In Baggage, proof of ownership in the form of purchase bill (or any other proof to the satisfaction of the Assistance Service Provider).

In case of compensation from the Common Carrier having been received after payment of the claim by the Company hereunder, the Insured shall repay to the Company such amount in excess of his/ her loss after taking into account the amount of claim received from the Company and at that received from the Common Carrier.

In case the undelivered Checked-In Baggage is subsequently traced by the Common Carrier and offered for delivery to the Insured, the Insured shall take delivery of the Checked-In Baggage and refund the amount paid by the Company hereunder. In case of delivery of part of the Checked-In Baggage, the amount paid by the Company attributable to such Checked-In Baggage shall be refunded by the Insured to the Company.

Documents to be submitted in support of the claim Checked-in Baggage Delay:

1. Property irregularity report stating the scheduled time of delivery and actual time of delivery of the Checked-In Baggage issued by the Common Carrier.
2. Voucher of the Common Carrier for the compensation paid for the delay in delivery of the Checked-In Baggage.
3. Copies of correspondence exchanged, if any, with the Common Carrier in connection with the delay in delivery of the Checked-In Baggage.

Dated: D D/ M M/ Y Y Y Y Place: _____

_____
Claimant's/ Insured's Signature

Annexure 4: PASSPORT LOSS

Please provide details of the incident leading to loss of passport _____

_____

Date of loss of Passport: D D/ M M/ Y Y Y Y Place of loss of Passport: _____

Expenses incurred in obtaining new passport: _____

Sr. No.	Details of Expenses	Date	Expenses in Foreign Currency
Total:			

Documents to be submitted in support of the claim:

1. Police Report in original.
2. Details of the attempts made to trace the passport.
3. Statement of claim for the expenses incurred.
4. Receipt for payment of charges for obtaining an emergency certificate at the place of loss of the passport.
5. Receipt for charges for obtaining duplicate passport at the Country of Residence of the Insured.

In event the passport originally reported lost being traced and made available to the Insured, anytime before the emergency certificate at the place of loss of the passport or the duplicate passport at the Country of Residence of the Insured is issued to the Insured, the Insured shall intimate the concerned authorities forthwith and apply for the refund of the money paid with the application for emergency certificate or duplicate passport, as the case may be. The Insured shall then refund to the Company such amount as has been refunded by the authorities.

Dated: D D/ M M/ Y Y Y Y Place: _____ _____

Claimant's/ Insured's Signature

Annexure 5: PERSONAL LIABILITY

Date of Loss: D D/ M M/ Y Y Y Y

Place of Loss: _____

Name of aggrieved Third Party: _____

Amount of Liability: _____

Documents to be submitted in support of the claim

1. Statement of claim furnishing particulars of the event leading t the liability/ details of injury/ property damaged.
2. Photocopy of the police report wherever reported.

Dated: D D/ M M/ Y Y Y Y Place: _____ _____

Claimant's/ Insured's Signature

Annexure 6: PERSONAL ACCIDENT & ACCIDENTAL DEATH (COMMON CARRIER)

Please state circumstances of accident i.e. how, when, where it took place: ____________________

____

Nature of Injury: ____________________

State diagnosis and nature of treatment/ surgery under taken: ____________________

Provide name, address & telephone number of Hospital/ Clinic: ____________________

Treating Doctor's Name & Qualifications: ____________________

Treating Doctor's Telephone Number: (O) ☐☐☐☐☐☐☐☐☐☐ (M) ☐☐☐☐☐☐☐☐☐☐

Dates of treatment: From D D/ M M/ Y Y Y Y To: D D/ M M/ Y Y Y Y

Attending Doctor's Report

Date doctor contacted: D D/ M M/ Y Y Y Y Time: H H: M M

Nature of Ailment: ____________________

State diagnosis and nature of treatment provided: ____________________

Describe any other disease or infirmity affecting present condition: ____________________

Was the accident due to Pregnancy: Yes ☐ No ☐

Was the accident due to any pre-existing condition: Yes ☐ No ☐ If yes, please give details: ____________________

Can the patient be evacuated back to the Republic of India? Yes ☐ No ☐

Loss Incurred (Please tick):

Death ☐

Permanent Total Disability: ☐ (Details) ____________________

Permanent Partial Disability: ☐ (Details) ____________________

Documents to be submitted in support of the claim:

1. Medical reports giving the details of the Accident, nature of Injury and the extent of disability.
2. In case of death of the Insured, death certificate issued by the Medical Practitioner who attended on the Insured.
3. Postmortem certificate to be produced if required by the Assistance Service Provider.
   Police report in original in case the Accident shall have taken place in a public place or premises.

Dated: D D/ M M/ Y Y Y Y Place: ____________________

____
Claimant's/ Insured's Signature

Annexure 7: HIJACK DISTRESS ALLOWANCE

Name of Carrier:

Port of Hijack:

Port of Release:

Dates of Hijack: From: D D/ M M/ Y Y Y Y To: D D/ M M/ Y Y Y Y

Time of Hijack: From: H H: M M

Documents to be submitted in support of the claim:

Certificate of Hijack from the aircraft/ ocean going vessels furnishing details of travel by the Insured, the fact of his/ her being held captive and confirmation of death, if death shall occur.

Dated: D D/ M M/ Y Y Y Y Place:

Claimant's/ Insured's Signature

Annexure 8: EMERGENCY CASH ADVANCE ASSISTANCE

Date of Loss: D D/ M M/ Y Y Y Y

Reason and circumstances of Loss: _____

Items lost: _____

Value of the Items lost: _____

I hereby declare that the above reason was the sole reason for the of my loss of travel funds. I also declare that there are no other sources of funds available to me and the financial assistance required by me are needed on an urgent basis to prosecute the remainder of my trip. I have made all efforts to recover my money unsuccessfully, and if I do secure my money at a future date, I shall repay to the Company the total claim amount given to me.

_____

SIGNED (Claimant or authorized person)

Relationship with the Insured: _____

Documents to be submitted in support of the claim:

Police report in original filed within 24 hrs of becoming aware of loss

Dated: D D/ M M/ Y Y Y Y Place: _____

_____

Claimant's/ Insured's Signature

Annexure 9: HOME INSURANCE

Address of property where loss was sustained: _____

Date of Loss: D D/ M M/ Y Y Y Y

Cause of Loss: _____

Exact description of nature of loss and it causes (in case of burglary, how was forceful entry gained into the premises and who is suspected of the same):

_____

Occupants of the premises at the time of loss/ by whom it was discovered: _____

Has the loss been reported to the proper authorities? Yes ☐ No ☐ Please give details of where and to whom the loss has been reported along with the date and time (If not reported, please give reasons for the same): _____

Details of any other insurance cover for the property: _____

Details of Loss Incurred:

Sr. No.	Items lost due to fire/ burglary	Amount
Total		

Documents to be submitted in support of the claim

1. First Information Report
2. Panchnama
3. Investigation Report by the Police
4. Fire Brigade Report
5. Estimate and final bills of repairers
6. Invoices of owned articles, if required by the Company
7. Legal opinion wherever required
8. The statement of claim furnishing the details of items lost and the values thereof duly supported by purchase bills wherever available. In the event of the purchase bills not being available, he/ she shall render such evidence as may be required by the surveyor for the latter to arrive at the value of the lost items.
9. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy.

Dated: D D/ M M/ Y Y Y Y Place: _____

_____
Claimant's/ Insured's Signature

Annexure 10: TRIP CANCELLATION & INTERRUPTION

Trip Cancelled/ ☐

Trip interrupted/ ☐

Also claiming for Trip Regained ☐

Reason for Trip Cancellation/ Interruption: _____

_____

Please detail out the above reason for trip cancellation/ interruption (how, where, when and reason for the same):

Trip Cancellation/ Interruption date: D D/ M M/ Y Y Y Y

Original Travel Dates:From: D D/ M M/ Y Y Y Y Time: H H: M M

Person Affected and Relationship with the Insured: (If not the Insured, please also provide address and contact details) _____

_____

_____

Details of Losses/ Expenses Incurred:

Sr. No.	Loss/ Expenses Details	Amount
Total:		

Documents to be submitted in support of the claim:

1. In case of cancellation of the Trip either in the Country of Residence of the Insured or any other intermediate place forming part of the Trip by the Common Carrier solely resulting from contingencies namely Earthquake, Storm, Flood, inundation, cyclone, tempest & Terrorism, duly completed claims form to be accompanied by:
   a. Confirmation of cancellation of the Trip from the Common Carrier detailing the circumstances of cancellation;
   b. Original used air ticket indicating the cost the ticket and receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the Trip the cancellation charges retained;
   c. Original bill and a receipt/ letter obtained from the hotel and/ or guest house and/ or any other paid residential accommodation (available for fee) indicating the amount paid for the accommodation, the refund given and the cancellation charges retained, wherever such accommodation has be arranged at the place of cancellation of the Trip;
   d. Used air ticket in original for return journey from the place of cancellation to the Country of Residence of the Insured which indicate the cost of the tickets together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip.
2. In case the cancellation of the Trip shall result because of personal contingencies covered hereunder or a decision taken at the instance of the Insured arising out of the contingencies namely Earthquake, Storm, Flood, inundation, cyclone, tempest & Terrorism, the duly completed claims form to be accompanied by:
   a. Medical evidence as may be required by the Assistance Service Provider in case of the cancellation of the Trip arising out of personal contingencies of the Insured or his/ her Immediate Family;
   b. Receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the Trip indicating the cancellation charges retained;
   c. Receipt/ letter obtained from the for the hotel and/ or guest house and/ or any other residential accommodation (available for a fee) indicating the cancellation charges retained, wherever such accommodation has be arranged at the place of cancellation of the Trip;
   d. Used air ticket or boarding pass in original for return journey from the place of cancellation to the Country of Residence of the Insured together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip.
3. In case the cancellation charges either for the Trip or part of it or in relation to the accommodation in a hotel/ guest house/ other residential accommodation is waived to the advantage of the Insured subsequent to any settlement of claim under this Benefit, the Insured shall forthwith return the sum paid by the Company to the extent of such waiver.

Dated: D D/ M M/ Y Y Y Y Place: _____ _____

Claimant's/ Insured's Signature

Annexure 11: MISSED (FLIGHT) CONNECTION

Original Travel Schedule: (Please give date and time of all flights, mentioning the original and actual arrival and departure times. Please also mention the name of carriers and flight numbers)

Which flight was delayed causing a missed connection? _____

Reason for delay of the flight: _____

Details of expenses due to Missed Connection:

Sr. No.	Expenses	Amount
Total		

Documents to be submitted in support of the claim:

1. The confirmation from the Common Carrier of the delayed flight as to the expected time of arrival and the actual time of arrival at the port of delay together with the reasons for delay.
2. Unused ticket for the ongoing flight (Missed Flight) with an endorsement of the Common Carrier of cancellation of the same.
3. Certificate from the Common Carrier of the Missed Flight that the fare for the part of the Trip covered by the Missed Flight is forfeited in full or in part together with the amount of forfeiture.
4. Original used ticket obtained afresh towards the alternative flight for the part of the Trip covered by the Missed Flight indicating the amount paid as fare.

In the event of the forfeited amount by the Common Carrier for the Missed Flight being refunded / returned to the Insured, subsequent to any payment under this section, the Insured shall return the amount so refunded in full.

Dated: D D / M M / Y Y Y Y Place: _____ _____

Claimant's/ Insured's Signature

Annexure 12: TRIP DELAY

Reason for Trip Delay: _____

Please detail out the reason for trip delay (how, where, when, what was lost and reason for the same): _____

Original Travel Dates: From: D D/ M M/ Y Y Y Y To: D D/ M M/ Y Y Y Y

Trip delayed on: D D/ M M/ Y Y Y Y

Person Affected and Relationship with the Insured: (If not the Insured, please also provide address and contact details) _____

_____

_____

Details of Expenses Incurred:

Sr. No.	Loss/ Expenses Details	Amount
Total		

Documents to be submitted in support of the claim:

In case of delay of the Trip either at the Country of Residence of the Insured or any other intermediate place forming part of the Trip by the Common Carrier solely resulting from contingencies namely Earthquake, Storm, Flood, inundation, cyclone, tempest & Terrorism, duly completed claims form to be accompanied by,

a. Confirmation of cancellation of the Trip from the Common Carrier detailing the circumstances of cancellation
b. Receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the Trip indicating the cancellation charges retained
c. Receipt / letter obtained from the hotel and / or guest house and / or any other residential accommodation for a fee indicating the cancellation charges retained by the agency, wherever such accommodation has be arranged at the place of cancellation of the Trip
d. Used air ticket or boarding pass in original for return journey from the place of cancellation to the Country of Residence of the Insured together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip (As any payment under this head shall be only in respect of the difference between the actual charges incurred for the return journey from the place of cancellation to the country of residence and the amounts obtained towards refund towards the unfulfilled portion of the Trip. These documents shall be submitted only in case there shall be an additional expenditure incurred by the Insured)

In case the delay of the Trip shall result because of personal contingencies covered hereunder or a decision taken at the instance of the Insured arising out of the contingencies namely Earthquake, Storm, Flood, inundation, cyclone, tempest & Terrorism, the duly completed claims form to be accompanied by:

a. A declaration from the Insured furnishing the circumstances that compelled him / her to cancel the Trip
b. Medical evidence as may be required by the Assistance Service Provider in case of the cancellation of the Trip arising out of personal contingencies of the Insured or his / her Family
c. Receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the Trip indicating the cancellation charges retained
d. Receipt / letter obtained from the for the hotel and / or guest house and / or any other residential accommodation for a fee indicating the cancellation charges retained by the agency, wherever such accommodation has be arranged at the place of cancellation of the Trip
e. Report filed with the Police having jurisdiction over the place of loss reporting the loss of the passport or travel documents and the application made for a fresh passport / travel documents.
f. Declaration from the Insured that the passport / travel documents has been recovered / returned to him / her with the date of such recovery / return or has not been recovered / returned or that alternative passport has not been obtained within the period for which the indemnity shall be available under the policy.
g. Used air ticket or boarding pass in original for return journey from the place of cancellation to the Country of Residence of the Insured together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip (As any payment under this head shall be only in respect of the difference between the actual charges incurred for the return journey from the place cancellation to the country of residence and the amounts obtained towards refund towards the unfulfilled portion of the Trip. These documents shall be submitted only in case there shall be an additional expenditure incurred by the Insured)

Dated: D D/ M M/ Y Y Y Y Place: _____

_____
Claimant's/ Insured's Signature

Annexure 13: BOUNCED BOOKINGS- AIRLINES/ HOTELS

Reason for Bounced Booking: _____

Please detail out the reason for the Bounced Booking (how, where, when, and reason for the same): _____

_____

_____

Original Travel/ Accommodation Dates: From: D D/ M M/ Y Y Y Y To: D D/ M M/ Y Y Y Y

Days on which the booking was bounced: D D/ M M/ Y Y Y Y

Details of Expenses Incurred: _____

Sr. No.	Loss/ Expenses Details	Amount
Total		

Documents to be submitted in support of the claim:

1. A declaration from the Insured that he/ she has strictly complied with the rules laid down by the Common Carrier or accommodation provider as the case may be relating to the reconfirmation of the booking prior to the date of departure of the flight or occupation of the accommodation.
2. A confirmation from the Common Carrier of the bounced booking solely at their instance and responsibility.
3. A confirmation from the accommodation provider of the bounced booking solely at their instance and responsibility.
4. Insured shall lodge his/ her claim on the Common Carrier and/ or the accommodation provider as the case may be for the additional charges that he/ she might have incurred for which he/ she has lodged a claim on this Company and in case of any recovery from the concerned agencies, shall return such recovery to the Company to extent of amount paid hereunder.

Dated: D D/ M M/ Y Y Y Y Place: _____

_____
Claimant's/ Insured's Signature

Annexure 14: COMPASSIONATE VISIT

Person Hospitalised: Insured ☐ Family Member ☐

Name of the person hospitalized (if not the Insured): _____

Relationship with the Insured: _____

Provide name, address & telephone number of Hospital/ Clinic: _____

Treating Doctor's Name & Qualifications: _____

Treating Doctor's Telephone Number:(O) _____ (M) _____

Dates of hospitalisation: From: D D/ M M/ Y Y Y Y Time: H H: M M

Date of onset of symptoms: D D/ M M/ Y Y Y Y

Attending Doctor's Report

Date on which doctor was contacted: D D/ M M/ Y Y Y Y Time: H H: M M

Nature of Ailment: _____

State diagnosis and nature of treatment provided: _____

When did patient's symptoms first appear? D D/ M M/ Y Y Y Y

Describe any other disease or infirmity affecting present condition: _____

Was the ailment due to Pregnancy: Yes ☐ No ☐

Was the ailment aggravated due to any pre-existing condition? Yes ☐ No ☐ If yes, please give details: _____

Can the patient be evacuated back to the Republic of India? Yes ☐ No ☐

Estimated time the patient would continue to be in the hospital? _____

Expenses Details

Sr. No.	Loss/ Expenses Details	Date	Amount
Total			

Documents to be submitted in support of the claim:

1. A certificate from the Medical Practitioner recommending the presence in the form of special assistance to be rendered by a member of the Family or near relative during the entire period of Hospitalization. Certificate to also specify the minimum period of Hospitalization.
2. Discharge summary of the Hospital furnishing details - date of admission, date of discharge, and the presence of the member of the Family or near relative on all days of Hospitalization.
3. Original ticket used for the travel to and fro by the member of the Family or near relative.

Dated: D D/ M M/ Y Y Y Y Place: _____

_____
Claimant's/ Insured's Signature

Annexure 15: EMERGENCY HOTEL EXTENSION

Reason for Delay: _____

Please detail out the above reason for Delay (how, where, when and reason for the same): _____

_____

_____

Delay date: D D/ M M/ Y Y Y Y

Original Travel Dates: From: D D/ M M/ Y Y Y Y To: H H: M M

Person Affected and Relationship with the Insured: (If not the Insured, please also provide address and contact details) _____

_____

Details of Losses/ Expenses Incurred:

Sr. No.	Loss/ Expenses Details	Date	Amount
Total			

Documents to be submitted in support of the claim:

1. Receipt for the amount paid to the hotel or guest house or any other accommodation provider for a fee for the charges per day paid towards accommodation.
2. Evidence as may be required by the Assistance Service Provider in case the delay is caused by Earthquake, Floods resulting from unseasonal rains, storm or cyclone or Terrorism.
3. Medical certificate furnishing details of date of admission and date of discharge together with the details of the Injury or Illness and the treatment rendered, obtained from the Medical Practitioner in case of delay being caused because of Hospitalization of the Insured or Insured's Family member or Traveling Companion resulting from any Injury or Illness to the Insured or Insured's Family member or Traveling Companion, as the case may be.
4. In case of loss of passport, a copy of the first information report in relation to the complaint lodged with the police having jurisdiction over the place of loss and a copy of the application lodged with the passport office for a duplicate passport.
5. In case of loss of travel documents, a copy of the report lodged with the Common Carrier for the loss of the travel documents and a confirmation from the latter that the Insured could not undertake the travel as scheduled.

In case of delay solely attributable to Common Carrier and beyond the control of the Insured a confirmation by the Common Carrier of the said delay having taken place at their instance together with a copy of the claim made on the Common Carrier for expenses incurred as a result of the delay.

Dated: D D/ M M/ Y Y Y Y Place: _____

_____
Claimant's/ Insured's Signature

Annexure 16: LOSS OF BAGGAGE & PERSONAL EFFECTS

Date of Loss: D D/ M M/ Y Y Y Y

Reason and circumstances of Loss: _____

I hereby declare that the above reason was the sole reason for the Loss of my baggage & personal effects. I have made all efforts to recover my baggage & personal effects unsuccessfully, and if I do secure my baggage & personal effects at a future date, I shall repay to the Company the total claim amount given to me. _____

_____

SIGNED (Claimant or authorized person) Relationship with the Insured

_____ _____

SIGNED (Claimant or authorized person) Relationship with the Insured

Details of Losses/ Expenses Incurred:

Sr. No.	Loss/ Expenses Details	Amount
Total:		

Details of compensation received: _____

Documents to be submitted in support of the claim:

1. Copies of the letter addressed to the Common Carrier, police authorities and hotel/ guest house/ accommodation provider with their acknowledgment.
2. Copy of the first information report lodged with the police in relation to the complaint.
3. Reply if any in original received from the above referred authorities.
4. Evidence as may be required by the Assistance Service Provider for certification of the market value of the items lost whose individual value shall have exceeded US$ 100.

Dated: D D/ M M/ Y Y Y Y Place: _____ _____

Claimant's/ Insured's Signature

Annexure 17: RETURN OF MINOR CHILD/ CHILDREN

In the Event of Hospitalisation

Person Hospitalised: Insured ☐ Family Member ☐

Name of the person hospitalized (if not the Insured):

Relationship with the Insured:

Provide name, address & telephone number of Hospital/ Clinic: ____________________

____

Treating Doctor's Name & Qualifications:

Treating Doctor's Telephone Number:(O) (M)

Dates of hospitalisation: From D D / M M / Y Y Y Y Time: H H : M M

Date of onset of symptoms: D D / M M / Y Y Y Y

In Case of Death of the Insured

Cause/ Circumstances of death:

Date of death of Insured:

Attending Doctor's Report

Date doctor contacted: D D / M M / Y Y Y Y Time: H H : M M

Nature of Ailment: ____________________

State diagnosis and nature of treatment provided:

When did patient's symptoms first appear?

Describe any other disease or infirmity affecting present condition:

Was the ailment due to Pregnancy: Yes ☐ No ☐

Was the ailment aggravated due to any pre-existing condition? Yes ☐ No ☐ If yes, please give details: ____________________

Can the patient be evacuated back to the Republic of India? Yes ☐ No ☐

Estimated time the patient would continue to be in the hospital? Yes ☐ No ☐

Is Medical Evacuation back to Republic of India needed? Yes ☐ No ☐ Please give detailed reasons of the ailment and reason for transportation: ____________

____

____

Expenses Details

Sr. No.	Details of Expenses	Date	Expenses in Foreign Currency/ INR
Total:			

Documents to be submitted in support of the claim:

1. A certificate from the Medical Practitioner recommending the presence in the form of special assistance to be rendered by a member of the Family or near relative during the entire period of Hospitalization. Certificate to also specify the minimum period of Hospitalization.
2. Discharge summary of the Hospital furnishing details – date of admission, date of discharge, and the presence of the member of the Family or near relative on all days of Hospitalization.
3. Original ticket(s) used for the travel by the Minor Child(ren) back to the Country of Residence, if the ticket(s) are bought on behalf of the Insured without any interference of the Company
4. Photocopy of the death certificate (wherever applicable) providing the details of the place, date and time, and the circumstances and cause of the death (photocopy of the postmortem certificate wherever required by the Assistance Service Provider, for cases where postmortem is conducted,), issued by the appropriate authority where the contingency has arisen.

Dated: D D / M M / Y Y Y Y Place:

____
Claimant's/ Insured's Signature

Annexure 18: POLITICAL RISK AND CATASTROPHE EVACUATION

Reason for Evacuation: _____

Please detail out the above reason for Evacuation (how, where, when and reason for the same): _____

_____

Evacuation date: D D/ M M/ Y Y Y Y Original Travel Dates: From: D D/ M M/ Y Y Y Y Time: H H: M M

Details of Losses/ Expenses Incurred: _____

Sr. No.	Loss/ Expenses Details	Amount
Total:		

Documents to be submitted in support of the claim:

1. Official Declaration by embassy of Country of Residence of the Insured.
2. Original Invoice of Hotel Accomodation during the period Insured is unable to return to the Country of Residence.
3. Original ticket(s) used for the travel back to the Country of Residence.

Dated: D D/ M M/ Y Y Y Y Place: _____

_____
Claimant's/ Insured's Signature

Annexure 19: BAIL BOND

Name and contact details of the detaining authority: _____

The offense for which the insured is in custody: _____

Is this offense bailable as per the laws of the country? Yes ☐ No ☐

Please attach the court order stipulating the required amount as bail bond. Please attach more sheets to give details, if necessary.

Dated: D D/ M M/ Y Y Y Y Place: _____ _____

Claimant's/ Insured's Signature

Annexure 20: SPONSOR PROTECTION

Name of the sponsor: _____

Cause of accident causing the demise of the sponsor: _____

Nature of injury causing the demise of the sponsor: _____

_____

_____

Place of accident of the sponsor: _____

Name, address and telephone number of hospital/ clinic where treatment was given to the sponsor: _____

_____

Name of treating doctor of the sponsor: _____

Details of medical/ surgical treatment given to sponsor: _____

Dates on which the sponsor was given medical/ surgical treatment: From: D D/ M M/ Y Y Y Y To: D D/ M M/ Y Y Y Y

Please attach medical reports, doctor's statement giving the details of the sponsor and cause of death, and the death certificate of the sponsor. Medical statements from relations/ spouse will not be accepted. Please attach more sheets to give details, if necessary.

Tuition fees Claimed: _____

Dated: D D/ M M/ Y Y Y Y Place: _____

_____
Claimant's/ Insured's Signature

Annexure 21: STUDY INTERRUPTION

☐ Due to hospitalisation of the insured

Name, address and telephone number of hospital/ clinic where treatment is being given: _____

_____

_____

_____

Name of treating doctor: _____

Details of ailment: _____

Cause of the ailment: _____

Was the ailment/ incident caused due to/ aggravated due to a pre-existing condition? Please give details: _____

_____

_____

_____

_____

Date of onset of ailment: D D/ M M/ Y Y Y Y Nature of treatment: _____

Dates of hospitalisation: From : D D/ M M/ Y Y Y Y To: D D/ M M/ Y Y Y Y

Reason for medical evacuation (if applicable): _____

Reason for not continuing studies abroad: _____

Tuition fees paid in advance for the year: _____

☐ Due to death of sponsor or immediate family member

Name of the sponsor/ immediate family member: _____

Cause of accident causing the demise of the sponsor/ reason for death of immediate family member: _____

Nature of accident causing the demise of the sponsor: _____

Place of accident of the sponsor: _____

Name, address and telephone number of hospital/ clinic where treatment was given to the sponsor/ the immediate family member: _____

_____

_____

_____

Name of treating doctor: _____

Details of medical/ surgical treatment: _____

Dates of medical / surgical treatment: From: D D/ M M/ Y Y Y Y To: D D/ M M/ Y Y Y Y

Reason for not continuing studies abroad: _____

Tuition fees paid in advance for the year: _____

Please attach medical reports, statements from the treating doctor and death certificate as proof of the above. Medical statements from relations or spouse will not be accepted. Please also attach the receipts of the university fees paid. Please attach more sheets to give details, if necessary.

Dated: D D/ M M/ Y Y Y Y Place: _____ _____

Claimant's/ Insured's Signature

ICICI Lombard

Nibhaye Vaade

Mailing Address: ICICI Lombard General Insurance Company Limited, Interface Building No.11, 401/402 4th Floor, New Link Road Malad (W), Mumbai - 400 064.
Registered Office Address: ICICI Lombard General Insurance Company Limited, ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.
Visit us at www.icicilombard.com • Mail us at customersupport@icicilombard.com
Toll Free No.: **1800 2666** • Chargable No.: **+91 92236 22666** • SMS Facility "**HEALTHCLAIM**" to 575758