

**Reliance Travel Care Policy
Claim Form**

Claim No.
For the office use only

Certificate/Policy No. Period From Period To

Details of Insured (To be filled in BLOCK LETTERS)

- Name of the Insured Mr. Ms.
- Address for Communication
Flat/Building/Door/Block No.
Road/Street/Sector
Area
Taluka/Village/District/City Pin Code
State Country
Phone Mobile
Overseas contact no if any
Email Fax
- Relationship of the Patient/Insured Person with the Insured Self Spouse Son Daughter
- Source of fund Business Profession Salary Agricultural Income SavingsOthers
- Monthly Income Upto ₹ 20,000 ₹ 20,001 to ₹ 50,000 ₹ 50,001 to ₹ 1,00,000 ₹ 1,00,001 and above
- Does Insured have any other insurance coverage out of India? Yes No (if yes, please provide the details)
Name of the Insurance Company
Policy No. Sum Insured ₹
Policy Start Date Policy End Date
Name of the Insured

Details of Patient/Insured Person (To be filled in BLOCK LETTERS)

- Name of the Patient/Insured Person Mr. Ms.
- Date of Birth 9. Sex: M F
- Address for Communication
Flat/Building/Door/Block No.
Road/Street/Sector
Area
Taluka/Village/District/City Pin Code
State Country
Phone Mobile
Email Fax

Claim Details

- Has the Emergency Assistance Service Provider been intimated? Yes No
If yes, please provide the reference number
- Passport No.
- Please indicate whether claim is respect of
 Medical Expenses Dental Care Expenses Repatriation/Evacuation Compassionate Visit
 Personal Accident Accidental Death -Common Carrier Loss of checked Baggage
 Delay of checked Baggage Loss of Passport Trip Delay Trip Cancellation/Interruption
 Missed Connection Hijack Distress Allowance Personal Liability Emergency Cash Assistance
 Home Burglary

An ISO 9001:2015 Certified Company

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|---|---|
| <input type="checkbox"/> Bounced Booking of Airline and Hotel | <input type="checkbox"/> Up-gradation to Business Class : Travel Form |
| <input type="checkbox"/> Return of Minor Child | <input type="checkbox"/> Fraudulent Charges (Payment Card Security) |
| <input type="checkbox"/> Political Risk and Catastrophe Evacuation | <input type="checkbox"/> Golfer's Hole in One |
| <input type="checkbox"/> Daily Allowance in case of Hospitalisation | <input type="checkbox"/> Fire Cover for Building (Home in India) |
| <input type="checkbox"/> Fire Cover for Contents (Home in India) | <input type="checkbox"/> Loss of International Driving License |
| <input type="checkbox"/> Adventure Sports | <input type="checkbox"/> Reinstatement of Sum Insured |

Important Guidelines :

- 1 Issuance of the form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract.
- 2 Please answer all questions completely. In case of insufficient space, please attach an additional sheet.
- 3 Please attach all bills, receipts, payment card slips pertaining to your claim.
- 4 No claim under Accident & Sickness Section will be admitted without Doctor's Report as per format.
- 5 Failure to call our Emergency Assistance Service Provider shall invalidate your claim.

Claimant's Bank details

14. Name of the Bank Account Holder
15. Bank Account No.: 16. Account: Saving Current
17. Name of the Bank
18. Branch 19. PAN No.
20. MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)
21. IFSC Code (11 character code appearing on your cheque leaf)

I understand that any refund due on the premium payment / any payment / claims to be directly credited to my aforesaid Bank Account.*

*As per IRDAI, its mandatory that all payments made to the insured are only through electronic mode.

Declaration

I, hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited, I further declare that, in respect of the above statement, no benefits are admissible under any other Medical scheme or Insurance.

I hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish to the company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records, a photostat copy of this authorization shall be considered as effective and valid as the original.

Date:

Place:

Signature of Insured Person

Contact Reliance General Insurance Company Limited : +91-22-67347843 (Paid) / +91-22-67347844 (Paid)

RCare ID: reliance@europ-assistance.in

UIN No.: RELTIOP08002V010708, RELTIOP07004V010607