

TRIP CANCELLATION / TRIP INTERRUPTION

Flight No. _____ Date ____/____/____ From _____ to _____
 Scheduled time of Departure: _____ Cause for Cancellation / Interruption : _____

Details of Expense incurred*	Date	Place	Amount
Amount refunded by Common Carrier and Hotel			
		TOTAL	

**Please note that this coverage applies if Trip is cancelled due to Illness, Injury or death to: You; Your Traveling Companion; Your Immediate Family Member.*

ACCIDENT MEDICAL BENEFIT

Details of accident i.e. how, when, where it took place: _____

 Date: _____ Place: _____
 Name & Address of consulting physician: _____

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

 Provide name & address of your treating physician: _____

 Provide name of any prescription medicine you are presently taking: _____
 Indicate other health insurance coverages, including name, address, policy number & certificate number of insurer: _____

DETAILS OF ACCIDENTAL MEDICAL EXPENSES

Details of treatment	In/ Out Patient		Charges	Status of Payment Paid/ Outstanding
	From	To		
			Paid	
			Outstanding	
			TOTAL	

AUTHORIZATION

I hereby declare that I have suffered injuries / loss as described above and all the details given are **ABSOLUTELY TRUE AND CORRECT**.
 I hereby agree to forfeit all my rights to compensation if any of the foregoing facts and / or details are found to be false or incorrect.
 I further authorise the hospital, doctor diagnostic laboratory, organisation, establishment or any other body or person dealt with in
 the course of this claim to give any information or document sought for by the Insurance Company.

Date: _____ Place: _____

Signature of insured :

Attending Doctor's Report

Patient's Name: _____ Age: _____ Sex: _____ M / F
 Address: _____

Date contacted: _____ Time: _____

Nature of Injury: _____

X-Ray Taken: Yes No Date taken: _____

Diagnosis and Treatment Given: _____

Describe any other disease or infirmity affecting present condition: _____

Signature: _____

Attending Doctor's Signature

NOTE : THIS FORM ALONG WITH THE DOCUMENTS TO BE SENT AT THE ABOVE ADDRESS.

THIS IS A COMMON CLAIM FORM.

KINDLY FILL THE RELEVANT SECTION AS APPLICABLE TO THE LOSS ADMISSIBLE UNDER POLICY ISSUED TO YOU.