STUDENT GUARD – OVERSEAS HEALTH INSURANCE PLAN - CLAIM FORM

IMPORTANT:

Please contact our 24-hour helpline (our Assistance Center) on

For the *Americas Policies: +1-833-440-1575 (Toll free within US &Canada)

Email: tata.aig@europ-assistance.in

For rest of the world policies excluding the Americas:Please Call: +91 – 022 68227600

Email: EA.TATAclaims@europ-assistance.in

(Americas include North, Central, South America & Canada)

Failure to call our Assistance Company, on 24-hour helpline, in respect of Medical Accident and Sickness Claims shall invalidate your claim, if any. Please note, the first US$100 of your expenses is deductible & must be borne by you

1. This is a One Call Claim Form, except for Accidental Death & Dismemberment, for which we shall provide a separate Claim Form upon notification.
2. Issuance of the form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract.
3. No claim under Accident & Sickness Section will be admitted without Doctor's Report as per format (Attending Doctor's Statement)
4. Please answer all questions completely. In case of insufficient space, please attach an additional sheet.
5. Please attach all bills, receipts, credit card slips pertaining to your claim.

Certificate/ Policy No._____ Period From _____ to: _____

DETAILS OF PATIENT/ INSURED PERSON

Name : _____ Phone Nos. _____

Permenant Address (India):_____

_____

Date of Birth: ___/___/____ Sex: M / F Passport No.: _____

Date of Departure: ___/___/___ Flight No. _____ From _____ to _____

Assistance Co. Case Ref. No.: _____ E-mail ID :

Name of Institute where studying: _____

Address: _____

_____

Contact Numbers: _____

Study Course Taken :

Student Identification Number: _____

Bank Account Details :_____

Account NAME.: _____PAN NO;_____

Bank Account No.: _____IFSC Code : _____ MICR Code : _____

Name of the Bank & Address : _____

_____

DETAILS OF INSURED PERSON'S GUARDIAN IN INDIA

Name : _____ Phone Nos. _____

Addres_____

_____

Relationship with Insured person: _____

Please indicate whether claim is in respec Accident & Sickness Medical Exp Personal Liability

Bail Bond Study Interruption Compassion Visit Sponsor Protection

Baggage Delay / Baggage Loss Trip Delay Misses Connection / Missed Departure

Please complete the Section relevant to your claim.

DELAY / LOSS OF CHECKED BAGGAGE

Describe when & where the loss took place: _____

_____

State the extent of Loss: _____

Name the common carrier: _____ Flight No. _____ From _____ to _____

Has the common carrier been notified at the time of loss? Yes No

Details of loss & compensation received from carrier:_____

Item Lost	Date of Purchase	Place	Cost
		TOTAL	
Less Compensation received from Airline:			
		Net Amount:	

TRIP DELAY

Flight No. _____ Date____/____/_____ From _____ to_____

Scheduled time of Departure:_____ Actual time of Departure: _____ No. of Hours delayed:_____

Whether accomodation & boarding provided by carrier: Yes No

Details of Expense incurred	Date	Place	Amount
		TOTAL	

MISSED DEPARTURE/ MISSED CONNECTION

Flight No. _____ Date____/____/_____ From _____ to_____
Scheduled time of Departure:_____ Actual time of Departure: _____ No. of Hours delayed:_____
Whether accomodation & boarding provided by carrier: Yes No

Details of Expense incurred	Date	Place	Amount
		TOTAL	

LOSS OF PASSPORT

Please provide details of the incident i.e. when, where and how it happened:_____
_____
_____
Details of Police Report (please attach copy): No:_____ Date:_____ Place:_____

Details of Expense incurred	Date	Place	Amount
		TOTAL	

PERSONAL LIABILITY / Fradulent charges

Please provide details of injury/ property damaged / Faradulent transactions:_____
_____
_____
Details of Amount Claimed: _____

BAIL BOND

Please provide details of the incident for which you have been arrested:_____
_____
_____
Date of Occurrence: ____/ ____/ ____ Location: _____ Time: _____
Booked under Section _____ of the Penal Code for _____
Name of Witnesses: _____
Address: _____
_____
Phone Nos:

STUDY INTERRUPTION

Reason for Interruption: _____
Study Course Duration (for which the Fees have been paid) : _____ Years _____ Months
Study Course Completed: _____ Years _____ Months
Total Fees Paid (Please mention Currency) : _____ for a Period of _____(Yrs./ Months)
(Please attach copies of the Fee Receipt)

COMPASSION VISIT

1. In case of your Illness and Hospitalisation:
Nature of Illness: _____
No. of Days Hospitalised: _____
Name and Address of Hospital: _____
_____
Name of Treating Doctor: _____
Name of Immediate Family Member: _____ Relationship: _____
Date of Travel: From ___/ ____/ ____ to ____/ ____/ _____ no. of Days: _____

1. In case of the Illness and Hospitalisation of your Parent(s)/ child(ren) in India:
Name of Immediate Family Member: _____ Relationship: _____
Nature of Illness: _____
No. of Days Hospitalised: _____
Date of Travel: From ___/ ____/ ____ to ____/ ____/ _____ no. of Days: _____

SPONSOR PROTECTION

Name of Sponsor: _____ Relationship: _____
Nature of Injury/ Illness: _____
Total Study Course Duration : _____ Years _____ Months
Total Fees Paid (Please mention Currency) : _____ for a Period of _____(Yrs./ Months)
Balance Fees Payable to Institute: _____

Hijacking

Flight No. _____ Date____/____/_____ From _____ to_____
Please provide details of incident:_____ _____

MEDICAL ACCIDENT & SICKNESS BENEFIT including Emergency Accident &SicknessDental Relief /Cancer screening and mammography examinations/ Physiotherapy / Ambulance Charges/ Treatment for mental and nervous disorders: including alcoholism and drug dependency / Maternity

If accident, details of accident i.e. how, when, where took place: _____
_____
Date: Place:
If sickness, advise when & where symptoms first occurred: _____
_____
Date:_____ Place: _____
Name & Address of consulting physician: _____
_____
Have you ever been treated for this illness before: Yes No
If yes, provide name & address of treating physician: _____
_____
Provide name & address of your family 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 treatment	In/ Out Patient		Charges (Currency)	Rupees
	From	To		
			Total Amount	
			Invoices Paid	
			Invoices Outstanding	

Whether authorisation obtained from Assistance Co: Yes No. If Yes, Reference No. _____
If No, give reasons: _____

I declare that the above answers are true and correct to the best of my knowledge and that I have not withheld any relevant information which might have otherwise affected theacceptance of my application. I understand and agree that the insurance applied for will become effective only upon acceptance by the company and the premium being fully paid.

Signature Date Place

AUTHORIZATION

I hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish to the company, or its authorised 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 photo static copy of this authorization shall be considered as effective and valid as the original.

Signature _____ Date _____ Place _____

Attending Doctor's Statement

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

For Accidental Injury

Nature of Injury: _____
_____
X-Ray Taken: Yes No Date taken: _____
Diagnosis and Treatment Given: _____
_____
_____
_____
Describe any other disease or infirmity affecting present condition: _____

Is present treatment / condition due to any pre-existing condition: Yes No

For Sickness

Nature of Illness: _____
_____
Diagnosis and Treatment Given: _____
_____
_____
_____
When did patient's symptoms first appear: _____
Describe any other disease or informity affecting present condition: _____
_____
Is condition due to Pregnancy: Yes No Is illness due to any pre-existing condition: Yes No

If Hospitalised, please provide the following details:

Name of Hospital/ Clinic: _____
Address: _____
_____
_____
Doctor's Name: _____

Date:

Signature:_____
Attending Doctor's Signature

CLAIMS DEPARTMENT
Tata AIG General Insurance Company Limited
A-501, 5th Floor, Building No.4, Infinity Park,
Gen. A.K. Vaidya Marg, Dindoshi, Malad (East), Mumbai 400 097.