

**INDUSIND TRAVEL CARE POLICY - EXTENSION REQUEST FORM**

(Request for Single Insured Only)

1. Name of Insured/Insured Person	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.	F	I	R	S	T	M	I	D	D	L	E	L	A	S	T
2. Name of Insurance Company																
3. Type of Policy/Plan																
4. Policy Number																
5. Period of Insurance	From DD/MM/YYYY To DD/MM/YYYY															
6. Date of Birth of Insured Person	DD/MM/YYYY										Age	_____ Years				
7. Required Extension Period	From DD/MM/YYYY To DD/MM/YYYY										Days	_____				
8. Reason for Extension:	<hr/> <hr/>															

9. Have you made any claim during the current Policy period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, details of claim made with approximate amount	
<hr/> <hr/>	

10. Are you in good health?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you undergone any treatment/medication, diagnosed with any illness/condition or suffered from any injury during the Policy period	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Start date of first policy with us on which continuous Extension is being sought	
13. Has any extension being made to the policy before this request? Yes No	
If YES, please mention the total duration of the Policy as on expiry of the last extension	
_____ days	

14. Where there is a break in Insurance, please provide the following information:	
• Reason for delay in approaching the Insurer for extension	
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• Any Pre-existing Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Any Hospitalisation during the period when there was no cover?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Insured has undergone any treatment/medication or suffered any injury during the same period	<input type="checkbox"/> Yes <input type="checkbox"/> No

Where the Insured answers YES to any of the above questions, please provide details:

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**Declaration**  
I hereby solemnly declare that the above information provided is true to the best of my knowledge and understanding. I agree and accept that IndusInd Insurance Co. Ltd. is not liable to pay for any claim towards disease / illness / injury whose signs / symptoms originated or related treatment taken or actual loss occurred during the break in period or may occur in future due to any incident occurred during break in period (if any)

Date: DD/MM/YYYY \_\_\_\_\_  
Place: \_\_\_\_\_

Name and Signature of the Insured \_\_\_\_\_

Note: No extension will be permitted in the event of any claim reported under the Medical Expenses section of the Policy.