

Claim No. _____

INDUSIND INLAND TRAVEL CARE POLICY - CLAIM FORM A

*Policy No./Certificate No. _____

HOSPITALIZATION EXPENSES/ EMERGENCY MEDICAL EXPENSES

In case of disease / illness

Please provide the details of the disease/illness _____

Please provide the cause of the disease / illness _____

Date of onset of disease / illness DD / MM / YYYY

In case of accident

Please provide the details of the accident _____

Please provide the cause of the accident _____

Date of the accident DD / MM / YYYY Place of the accident

 Please specify whether the Patient/Insured person was hospitalized for treatment of disease/illness/injury ☐ Yes ☐ No

If yes, period of Hospitalization/Treatment done for disease/illness/injury From DD/MM/YYYY To DD/MM/YYYY

Nature of Treatment done for disease/illness/injury _____

Name of the hospital/Nursing Home where treatment of the disease/illness/injury was given _____

 Address
 Flat/Building/Door/Block No.

Road/Street/Sector

Area

Taluka/Village/District/City

Pin Code

State

Country

Telephone No.

Fax

 Name of the Attending
 Doctor / Physician

Dr. _____

 Address
 Flat/Building/Door/Block No.

Road / Street / Sector

Area

Taluka/Village/District/City

Pin Code

State

Country

Telephone No.					
Email					Mobile
Fax					
a. Was the disease/illness/injury caused and/or aggravated by any pre-existing condition/disease/illness/injury?					☐ Yes ☐ No
If Yes,					
b. Has the Patient/insured person been treated for the disease/illness/injury? Please specify the necessary details of the treatment received					
c. Name of the Consulted Physician	Dr. _____				
d. Address of the Consulted Physician Flat/Building/Door/Block No. Road / Street / Sector Taluka/Village/District/City State Mobile	Area Pin Code Country Fax				
e. Telephone Number of the Consulted Physician					
Please specify the names of the prescription medicines that the Patient/Insured person is presently taking, if any					
Please provide the details of the expenses related to your treatment					
Detail of Expenses	In/Out Patient		Charges (Currency)	Rupees	
	From	To			
			Paid		
			Outstanding		
			Total Due		

Date of Departure DD / MM / YYYY

Date of Arrival DD / MM / YYYY

Flight No.

From DD/MM/YYYY To DD/MM/YYYY

PNR No.

In case of a claim for emergency evacuation:

Cause of disease/illness/injury leading to evacuation:

Date of injury or commencement of disease/illness: DD / MM / YYYY Place _____

In case of a claim for repatriation of remains/funeral expenses:

Cause of Death

Date of Death DD / MM / YYYY

Place of Death

Please provide the details of the expenses related to the repatriation/funeral/evacuation

[illegible]

Attending Physician's Statement (To be filled up by the Attending Doctor/Physician)

Please provide the following details of the Patient/Insured Person

Name

Age

Yrs.

Sex ☐ M ☐ F

Address

Flat/Building/Door/Block
No.

Road / Street / Sector

Area

Taluka/Village/District/
City

Pin Code

State

Country

Phone No.

Fax

Email ID

Please specify the date & time when the Patient/Insured Person first contacted you

Please provide the details of the diagnosis and treatment given for the disease/illness/ injury



Please provide the details of medical investigation done, if any

In case of accidental injury

Does the cause of accident as stated by the Patient/Insured Person tally with the injuries noticed by you?

Was the Patient/Insured Person suffering from any condition/disease/illness/injury which may have contributed to the accident or likely to aggravate his/her condition ☐ Yes ☐ No

If yes, please specify the necessary details

Was the Patient/Insured Person under the influence of alcohol or intoxicants or drugs at the time of accident? ☐ Yes ☐ No

If yes, please specify the necessary details

In case of disease/illness

When did the Patient/ Insured Person's symptoms first appear?

Please specify the cause of the disease/illness

Was the disease/illness caused and/or aggravated due to any pre-existing condition/ disease/illness/ injury ? ☐ Yes ☐ No

If yes, please give the necessary details

Is the condition due to pregnancy? ☐ Yes ☐ No

Was the Patient/Insured Person hospitalized for the treatment of the disease/illness/injury?

If yes, please provide the following details

Period of Hospitalization From DD/MM/YYYY To DD/MM/YYYY

Name of Hospital/ Nursing Home where treatment of the disease/illness/injury was given

Address Flat/Building/Door/Block No.		
Road / Street / Sector		Area
Taluka/Village/District/ City		Pin Code
State		Country
Phone No.		Fax

Name of the Attending Doctor / Physician	Dr. _____		
Address Flat/Building/Door/Block No.			
Road / Street / Sector			Area
Taluka/Village/District/ City			Pin Code
State			Country
Telephone No.			Mobile
Email			Fax
			Date : DD / MM / YYYY
Attending Doctor's/Physician's Signature		Place : _____	

PROPOSER'S BANK DETAILS

Name of the Bank Account Holder	☐ Mr. ☐ Ms. ☐ Mrs. F I R S T M I D D L E L A S T		
Bank Account No.:	Account:	☐ Saving ☐ Current	
Name of the Bank			
Branch			
MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)			
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.

* Mandatory details to be filled

PEP DECLARATION:

Are you a Politically Exposed Person (PEP)?	☐ Yes ☐ No
If yes, please mention the position held	
Is any of your close relation or family member a PEP?	☐ Yes ☐ No
If yes, please mention the name and relation and the position held by such close relative/family member.	

I hereby declare that in future if me, any of my close relatives or any of my family member attains a position of PEP then I shall confirm the same to IndusInd General Insurance Co. Ltd as a mandate. I understand that this is a crucial information under the PMLA Rules and AML/CFT Guidelines and shall confirm that the answers given by me is true. In case the company comes to know that this is a misrepresentation and concealment of information then the policy shall be put on hold for scrutiny by the company and I shall be solely responsible for the same.

Note :

"Politically Exposed Persons" (PEPs) shall have the meaning assigned to it under sub clause (db) of clause (1) of Rule 2 of the Prevention of Money Laundering (Maintenance of Records) Rules, 2005."

(db) "Politically Exposed Persons" (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials".

AML Guidelines

1. I/We hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been /will be paid out of proceeds of crime related to any of the offense listed in Prevention of Money Laundering Act,2002.
2. I Understand that the Company has the right to call for document to established sources of funds.
3. The Insurance Company has right to cancel the insurance contract in case I am/have been found guilty by competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

Place: _____

Date: _____

Signature of Proposer

GENERAL DECLARATION:

I understand that as per the new AML/CFT Guidelines issued IndusInd General Insurance Co. Ltd will be verifying my details pertaining to KYC and PAN provided at the time of proposal.

I further, do hereby agree and consent that in the case of the event of a mismatch of information provided by me in the proposal form, identification proof, and address proof at the time of issuance of the policy. I request IndusInd General Insurance Company Limited to issue the policy with the details appearing as per my proposal form. I will be solely responsible for any consequences arising out of the difference in detail given by me during the verification of supporting documents provided by me at the time of issuance of the policy or otherwise.

HEALTH CARE ADDRESS:

Health Care Unit: IndusInd General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad - 500081. **Email:** healthcare@indusindinsurance.com.



indusindinsurance.com



022 4890 3009 (Paid)



74004 22200 (WhatsApp)

