

Claim No. _____

INDUSIND OVERSEAS TRAVEL CARE POLICY - CLAIM FORM A

Type of Claim ☐ Hospitalisation ☐ OPD															
MEDICAL EXPENSES / DENTAL CARE EXPENSES															
1.	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														
2.	In Case Of Accident Please Provide The Details Of The Disease / Illness _____ Please Provide The Cause Of The Disease / Illness _____ Date Of The Accident DD / MM / YYYY Place Of The Accident _____														
3.	Please Specify Whether The Patient/Insured Person Was Hospitalized For Treatment Of Disease/ Illness/Injury ☐ Yes ☐ No														
4.	If yes, period of Hospitalization/Treatment done for disease/illness/injury: From DD / MM / YYYY To DD / MM / YYYY														
5.	Nature Of Treatment Done For Disease/Illness/Injury _____														
6.	Name Of The Hospital/Nursing Home Where Treatment Of The Disease/Illness/Injury Was Given _____														
7.	<table border="1" style="width: 100%;"> <tr> <td colspan="2">Hospital Address</td> </tr> <tr> <td colspan="2">Address for Communication Flat/Building/Door/Block No. _____</td> </tr> <tr> <td colspan="2">Road/Street/Sector _____</td> </tr> <tr> <td colspan="2">Area _____</td> </tr> <tr> <td>Taluka/Village/District/City _____</td> <td>Pin Code _____</td> </tr> <tr> <td>State _____</td> <td>Country _____</td> </tr> <tr> <td>Telephone No. _____</td> <td>Fax _____</td> </tr> </table>	Hospital Address		Address for Communication Flat/Building/Door/Block No. _____		Road/Street/Sector _____		Area _____		Taluka/Village/District/City _____	Pin Code _____	State _____	Country _____	Telephone No. _____	Fax _____
Hospital Address															
Address for Communication Flat/Building/Door/Block No. _____															
Road/Street/Sector _____															
Area _____															
Taluka/Village/District/City _____	Pin Code _____														
State _____	Country _____														
Telephone No. _____	Fax _____														
7.	Name Of The Attending Doctor / Physician Dr. _____														


indusindinsurance.com


022 4890 3009 (Paid)



74004 22200 (WhatsApp)



Address Flat / Building / Door /
Block No.

Road / Street / Sector

Area

Taluka/Village/District/City

Pin Code

State

Country

Telephone No.

Mobile

Email

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

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

[illegible]

c.	Family Physicians Name
----	------------------------

Contact No.

Email ID

d. Regular Dentist Name

Contact No.

Email ID

REPATRIATION OF REMAINS/EMERGENCY EVACUATION

8. Date of Departure DD/MM/YYYY

9. Date of Arrival DD / MM / YYYY

10. Flight No.

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

In case of a claim for emergency evacuation:

11. 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:

12. Cause of Death

Date of Death DD / MM / YYYY

Place of Death

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

Detail of Expenses incurred

Date

Place

Amount

Total Due

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

14. Please provide the following details of the Patient/Insured Person

Name

Age

Yrs.

Sex ☐ M ☐ F

Phone No.

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

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

17. Please provide the details of medical investigation done, if any

18. 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	
19.	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 Date : DD/MM/YYYY
_____ Attending Doctor's/Physician's Signature Place : _____	

COMPASSIONATE VISIT	
20.	Please specify the details of the disease/illness/injury
21.	Date of Accident/Onset of Ailment
22.	Was the Patient/Insured Person Hospitalized? ☐ Yes ☐ No
23.	Period of Hospitalization From DD/MM/YYYY To DD/MM/YYYY
24.	Please provide the details of the treatment given



25.	Please provide the following details of the Hospital/Nursing Home where the treatment for disease/illness/injury was taken	
	Address for Communication Flat/Building/Door/Block No.	
	Road/Street/Sector	
	Area	
	Taluka/Village/District/City	Pin Code
	State	Country
	Telephone No.	Mobile No.
	Fax	Email ID
26.	Was the disease/illness/injury caused due to or aggravated by any pre-existing condition/disease/illness injury: ☐ Yes ☐ No	
	If yes, please specify the necessary details	
	In the opinion of the treating doctor, how many days of hospitalization would the Patient/Insured Person require?	
27.	In the opinion of the treating doctor, is there a need for an attendant for the Patient/Insured Person	

ADDED BENEFIT IF APPLICABLE	
1.	Up-gradation to Business Class
i.	Name of the Hospital: _____
ii.	Hospital Address: _____
iii.	Illness/Final Diagnosis given by the hospital/Treating Doctor. _____
	Date of Admission: D D / M M / Y Y Y Y Date of Discharge : D D / M M / Y Y Y Y
iv.	Details of Treating Physician.
	Name: _____
	Address: _____
	Registration Number: _____ Contact Number : _____
v.	Reason for Upgrade to Business Class.

2.	Return of Minor Child In the Event of Hospitalization/Death
i.	Name of the Minor: _____
	Contact Details: _____
ii.	Relationship With the Insured: _____

iii. Date of Return: DD/MM/YYYY	Total Expenses : DD/MM/YYYY
iv. Name of the Hospital: _____	
v. Hospital Address: _____	
Illness/Final Diagnosis given by the hospital/Treating Doctor. _____	
Date of Admission: DD/MM/YYYY	Date of Discharge : DD/MM/YYYY
vi. Date of Death (If Applicable): DD/MM/YYYY	

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.

