TRAVEL CLAIM FORM (MEDICAL EXPENSES)

Royal Sundaram
General Insurance

FOR OFFICE USE ONLY

Issuing office :________________________ Date of Issue : ___________________ Claim Number : ___________________________

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

Please ensure that all questions are answered in Capital Letters

MANDATORY

Policy Number

Name of the Insured

Name of the Claimant

Current Residential Address (overseas)

City State

Pincode Telephone -

Mobile E-mail

Permanent Address (In India)

City State

Pincode Telephone -

Date of commencement of Trip D D M M Y Y Y Y Scheduled/Actual date of return to India D D M M Y Y Y Y

Claim made on: ☐ Reimbursement basis ☐ Cashless guarantee through Overseas Alarm Center

PLEASE FILL THIS COLUMN IF YOU HAVE OPTED MULTI TRIP POLICY

Have you undertaken any journey overseas after the commencement of this policy? ☐ YES ☐ NO

If 'Yes' please state the total number of days on each tour

Places visited	Number of days

NATURE OF CLAIM (Please fill in the appropriate section (a) or (b) as applicable)

a) Accident

How did the accident occur?

b) Sickness

Nature of illness

Whether treated as ☐ In Patient ☐ Out Patient

Date of Admission to Hospital D D M M Y Y Y Y

Name and address of the Consulting Physician

Have you ever been treated for this illness before? ☐ YES ☐ NO

If 'Yes', details of treatment taken

Name and address of your regular physician in India

Details of expenses incurred

Sl. No.	Bill Number	Date	Description of expenses	Amount
1		D D M M Y Y Y Y		
2		D D M M Y Y Y Y		
3		D D M M Y Y Y Y		

(Attach separate sheet if you require more space)

Declaration

I hereby declare that the foregoing statements made are true and correct to the best of my knowledge and I have not attempted to conceal anything of material importance. I agree that if I have made, or will make any false or fraudulent statement whatsoever, the policy shall be void and my right to compensation forfeited.

Date: D D M M Y Y Y Y

Signature or thumb impression of the Insured

Authorisation

I, the undersigned authorise any hospital, medical-care institution, physician or other medical professional, pharmacy to provide any and all medical information in respect of which consultation was made and treatment given, to the Insurance Company or its representatives.

Date: D D M M Y Y Y Y

Signature or thumb impression of the Insured

TO BE FILLED IN BY THE MEDICAL PRACTITIONER

Patient Identity Number (Inpatient or Outpatient Number)

Patient Name

If the Injury was sustained by an accident, please describe

Nature and cause of accident

Extent of injury sustained

Was he/she to your knowledge under the influence of Intoxicants or drugs at the time of accident ☐ YES ☐ NO

If the treatment given is for illness/sickness/disease, please furnish

Diagnosis or nature of illness

Is the patient suffering from any of the following diseases. If "yes" Please mention the duration below.

S. No	Diseases	Yes/No	Duration in Year	Duration in Month
1	Bronchial Asthma	☐ YES ☐ NO		
2	Chronic Obstructive Pulmonary disease	☐ YES ☐ NO		
3	Hypertension	☐ YES ☐ NO		
4	Diabetes	☐ YES ☐ NO		
5	Heart ailment	☐ YES ☐ NO		
6	Osteoarthritis	☐ YES ☐ NO		
7	Cerebro vascular attack	☐ YES ☐ NO		
8	Seizure disorder	☐ YES ☐ NO		
9	Renal/Kidney Disorder	☐ YES ☐ NO		
10	Any other	☐ YES ☐ NO		

How long in your opinion could this ailment be existing?
(Sign of first symptom appearing)

If admitted in a hospital,

Name and address of the hospital

Date of Admission D D M M Y Y Y Y

Date of Discharge D D M M Y Y Y Y

Nature of Treatment given

Does the illness/sickness warrant the treatment given in the country of visit ☐ YES ☐ NO

Present condition

In case of Disablement Claim:

Nature of Disablement

Extent of Disablement: Permanent Total / Permanent Partial / Temporary Disablement

Percentage of Disablement :

In case of partial disablement (Please specify in %) ____%

In case of temporary disablement (Please specify period) From :_______________ To:________________

Any other remarks you wish to make

I hereby certify that the details given are true and correct to the best of my knowledge.

Name of Doctor

Qualification & Credentials

Address

Signature and seal of the Doctor

Claim Documents to be submitted - Check List

- ☐ Claim Form Duly signed
- ☐ Copy of the claim intimation, if any
- ☐ Hospital Main Bill
- ☐ Hospital Break-up Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bill
- ☐ Doctor's request for investigation
- ☐ Investigation Reports (Including CT/MRI/USG/HPE/ECG)
- ☐ Doctor's prescription for medicines purchased outside the hospital
- ☐ Test report and prescription relating to first consultation for the illness
- ☐ Hospital advance and final receipts
- ☐ FIR/MLC in case of accident injury and English translation of the same if it is in any other language
- ☐ Cancelled Cheque leaf of the bank account held in the name of the primary insured
- ☐ KYC document (Address proof, ID proof only for claims exceeding Rs.1 Lakh)

Additional Information :

Royal Sundaram General Insurance Co. Limited
(Formerly known as Royal Sundaram Alliance Insurance Company Limited)
Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097. Registered Office: 21, Patullos Road, Chennai - 600 002.
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