EDELWEISS GROUP DOMESTIC TRAVEL INSURANCE CLAIM FORM

Edelweiss | GENERAL INSURANCE

Toll Free 1800 12000

Instructions:
1. This form should be filled in by the insured person/claimant.
2. Issuance of this form does not imply acceptance of liability.
3. Please fill all the details in BLOCK LETTERS.
4. All fields in this form are mandatory.
5. If there is any other information to be provided, please write the same in a separate sheet, sign the sheet and attach it to this form.

SECTION A – DETAILS OF INSURED PERSON

a)Master Policy No.:

b)Name of the Master Policyholder:

a) Certificate No:

b) Edelweiss General Insurance Co. Ltd./TPA//Policyholder issued ID card no.:

c) Name of Insured Person:

d) Photo identity document and number:

e) Passport Number (wherever applicable):

f) Address as per photo identity proof:

City: State: Country: Landmark:

Date of Joining/Associating: D D M M Y Y Y Y Postal Code:

Phone Number: Email:

g) Name of Employer (if applicable):

Employee No.: Branch Location:

SECTION B – DETAILS OF INSURED PERSON/CLAIMANT CLAIMING FOR COVERAGE UNDER THE POLICY

a) Name of the Insured Person/ Claimant:

b) Photo Identity Document and Number:

c) Gender: Male Female Third Gender d) Age: years Y Y months M M e) Date of Birth: D D M M Y Y Y Y

f) Relationship with Insured Person(s): Self Spouse Child Father Mother Other: (Please Specify)

g) Occupation: Service Self-employed Homemaker Student Retired Other: (Please Specify)

h) Current Residential Address (if different from above):

City: State: Country: Postal Code:

Phone Number: Email ID:

SECTION C – BENEFIT BEING CLAIMED FOR

Death Permanent Partial Disability Permanent Total Disability Temporary Total Disability

Accidental Hospitalization Others (Please Specify):

a) Place of Treatment: State City Please mention the details here:

b) Name of Hospital where Hospitalized:

Address of the Hospital:

Landmark: Country: Town/ City: Postal Code:

c) Details of the Accident/event:

d) Hospitalization due to: Injury Sickness e) Date of Injury/contracting Illness/Sickness: D D M M Y Y Y Y

f) Date of Admission: D D M M Y Y Y Y g) Date of Discharge: D D M M Y Y Y Y

h) If due to Injury, give cause: Self-inflicted Road Traffic Accident Substance Abuse/Alcohol Consumption

i) Medico-legal: (i)Yes No (ii) Reported to Police: Yes No iii) MLC & FIR attached: Yes No

j) If claiming for any other benefit, please provide details:

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SECTION D – DETAILS OF CLAIM

a) Name of benefit(s) claimed with details: _____

i) Out-patient Expenses / Emergency Room/Casualty Expenses	₹	xii) Missed event	₹
		xiii) Total loss of baggage	₹
ii) Pre-existing Disease Cover	₹	xiv) Delay of baggage	₹
iii) Disappearance	₹	xv) Denied hotel accommodation	₹
iv) Funeral Expense	₹	xvi) Damage Baggage	₹
v) Child education	₹	xvii) Hijack distress compensation	₹
vi) Hospital Daily Allowance (Daily Cash)	₹	xviii) Bail Bond	₹
vii) Cancellation of Trip	₹	xix) Adventure sport cover	₹
viii) Trip Delay	₹	xx) Electronic equipment cover	₹
ix) Carrier Cancellation	₹	xxi) Personal liability	₹
x) Missed Carrier	₹	xxii) Felonious Assault / Kidnapping / Hijack / Riots	₹
xi) Denied boarding	₹	xxiii) Any other benefit or coverage	₹
Total:	₹		

Documents Submitted – Checklist

- ☐ Duly signed Claim Form
- ☐ Copy of the claim intimation, if any
- ☐ Hospital main bill
- ☐ FIR from police authorities, wherever necessary (in case of accidents outside residence)
- ☐ Death Certificate from the municipal authorities and Death Summary from hospital authorities
- ☐ Post Mortem Report (if conducted)
- ☐ Inquest Report/Panchnama
- ☐ Coroner's report/forensic science laboratory report (if available)
- ☐ Fitness certificate (if available)
- ☐ Any other document(s) required for assessment of claim as per benefit opted

SECTION E – DETAILS OF ASSISTANCE SERVICES (Tick the right option)

a) Emergency Medical Evacuation ☐ b) Medical Repatriation ☐

c) Repatriation of Mortal Remains ☐ d) Compassionate (Parental/Spouse Accommodation) ☐

SECTION F – DETAILS OF BANK ACCOUNT OF INSURED PERSON/CLAIMANT

a) PAN: ☐☐☐☐☐☐☐☐☐☐ b) Bank Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c) Bank Name and Branch: _____

d) Cheque/DD payable details: ☐☐☐☐☐☐☐☐☐ e) IFSC: ☐☐☐☐☐☐☐☐☐☐☐

F – DECLARATION BY THE INSURED PERSON/CLAIMANT (PLEASE READ VERY CAREFULLY)

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppressed or concealed any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize Edelweiss General Insurance Co. Ltd., its authorized TPA and ASP to seek necessary medical information/documents from any hospital/medical practitioner, who has attended on the person against whom this claim is made, and agree to provide necessary assistance in relation to assessment/settlement of this claim. I hereby declare that I have included all the bills/receipts/available documents for the purpose of this claim & that I will not be making any supplementary claim.

Date : ☐D ☐D ☐M ☐M ☐Y ☐Y ☐Y ☐Y

Place: _____

Signature
of the Insured Person/Claimant