# Health Insurance
## Aditya Birla Health Insurance Co. Limited
(A subsidiary of Aditya Birla Capital Ltd.)

ADITYA BIRLA CAPITAL
PROTECTING INVESTING FINANCING ADVISING

# Group Activ Travel - Claim Form

**1. Details of the Primary Insured / Claimant:**

a) Insurance Certificate Number:

b) Name of the Insured / Corporate:

c) Name of the Employee:

d) Name of Claimant:

e) Contact Number Overseas:

f) Permanent Address:

City: State: PIN:

g) Phone No – Mobile Home Work:

h) Email ID:

i) Date of Birth: D D M M Y Y Y Y

j) Passport Number:

k) Date of Departure: D D M M Y Y Y Y Flight Number: From: To:

l) Date of Arrival: D D M M Y Y Y Y Flight Number: From: To:

m) Claim Intimation Reference Number:

**2. Benefit availed:**

| Sr No | Name of Benefit | Select | Sr No | Name of Benefit | Select |
|---|---|---|---|---|---|
| 1 | Medical Cover: a. 1. In-patient Care with day care treatment (OR) | | 18 | Common Carrier Fatality | |
| | | | 19 | Personal Liability | |
| 2 | Medical Cover: a. 2. In-patient Care For Injury with day care treatment | | 20 | Hijack distress allowance | |
| | | | 21 | Optional Extension 9: Self-Inflicted Injury | |
| 3 | Optional Extension 1: Pre-Existing Disease Cover In Life Threatening Medical Condition | | 22 | Optional Extension 10: Maternity Complications | |
| 4 | Optional Extension 2: Extended Cover in the Country of Residence | | 23 | Optional Extension 11: Restriction / Sub-Limit On Medical Expenses | |
| 5 | Optional Extension 3: Automatic Extension (maximum up to 7 days) | | 24 | Optional Extension 12: Adventure Sports Injury | |
| | | | 25 | Optional Extension 13: Professional Sports Injury | |
| 6 | Optional Extension 4: Additional Sum Insured In Case Of Accident | | 26 | Optional Extension 14: Corporate Floater (Limits are at a Policy Level) | |
| 7 | Optional Extension 5: Maternity | | 27 | Out Patient Cover: a. 1. Out-patient Care; | |
| 8 | Optional Extension 6: Treatment of Mental & Nervous Disorder | | 28 | Out Patient Cover: a. 2. Out-patient Care for Injury | |
| | | | 29 | Optional Extension 1 : Cancer screening & Mammography | |
| 9 | Optional Extension 7: HIV / AIDS Cover | | 30 | Optional Extension 2 : Treatment of Mental & Nervous Disorder | |
| 10 | Optional Extension 8: Drug And Alcohol Abuse | | 31 | Optional Extension 3 : Radiotherapy and Chemotherapy Charges | |
| 11 | Medical Evacuation | | 32 | Optional Extension 4 : Vaccination Charges | |
| 12 | Repatriation of Mortal Remains | | | | |
| 13 | Dental Expenses | | 33 | Optional Extension 5 : Non-emergency OPD consultation | |
| 14 | Loss of Passport | | | | |
| 15 | Loss of Checked-in Baggage | | 34 | Optional Extension 6 : Psychological and Mental Counselling | |
| 16 | Delay of Checked-in Baggage | | | | |
| 17 | Personal Accident | | 35 | Home Care | |

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| | | | | | |
|---|---|---|---|---|---|
| 36 | Maternity Cash Benefit | | 55 | Re-imbursement of Golf fees and other non - transferable ticket expenses | |
| 37 | Loss of Laptop/ Tablet / Hand baggage / Mobile | | | | |
| 38 | Parent Accommodation | | 56 | Domestic Help post hospitalization | |
| 39 | Health Check-up | | 57 | Home Burglary | |
| 40 | Bail Bond | | 58 | Emergency Home Visit | |
| 41 | Emergency Cash Advance | | 59 | Lifestyle Support (Due to Accident only) | |
| 42 | Trip Cancellation & Interruption | | 60 | Missed Carrier | |
| 43 | Trip Delay | | 61 | Sponsor Protection | |
| 44 | Missed Connection | | 62 | Study Interruption | |
| 45 | Identity Document Theft | | 63 | Coverage in City of Residence for Medical Cover | |
| 46 | Bounced Booking | | 64 | Coverage in City of Residence for Personal Accident | |
| 47 | Political Risk and Catastrophe Evacuation | | 65 | Coverage in City of Residence for Daily Allowance | |
| 48 | Compassionate Visit | | 66 | Mugging Cover | |
| 49 | Return of Minor Child | | 67 | Mid Trip Medical cover continuance in India | |
| 50 | Up-gradation to Business Class | | 68 | Coverage in City of Residence for Out-patient | |
| 51 | Daily Allowance | | | Cover | |
| 52 | Replacement of Staff | | 69 | Coverage in City of Residence for Loss of Laptop/ | |
| 53 | Emergency Hotel Accommodation / Extension | | | Tablet / Hand baggage / Mobile | |
| 54 | Hotel Cancellation | | 70 | Coverage in City of Residence for Home Burglary | |

### 3. Details of Medical Claim

| | | |
|---|---|---|
| ☐ Medical Cover & Extensions | ☐ Outpatient Cover & Extensions | ☐ Medical Cover & Extensions |
| ☐ Repatriation of Mortal Remains | ☐ Dental Expenses | ☐ Repatriation of Mortal Remains |
| ☐ Common Carrier Fatality | ☐ Home Care | ☐ Common Carrier Fatality |
| ☐ Mid Trip Medical Cover continuance in India | ☐ Domestic Help Post Hospitalization | ☐ Mid Trip Medical Cover continuance in India |

a) Name & Address of Overseas Consulting Physician:

City: State: PIN:

b) Phone Number of Overseas Consulting Physician:

c) Email ID of Overseas Consulting Physician:

d) Name & Address of Family Physician:

City: State: PIN:

e) Phone Number of Family Physician

f) Email id of Family Physician:

g) Diagnosis:

h) Date of Admission: D D M M Y Y Y Y Date of Discharge: D D M M Y Y Y Y

i) If sickness-state nature of diagnosis and advise when and where symptoms first occurred:

j) Kindly confirm nature of Injury: ☐ Self Inflicted ☐ Accident

k) Substance Abuse/Alcohol Consumption at the time of accident: ☐ Yes ☐ No

l) If Accident kindly confirm how where and when it happened:

m) Kindly confirm if accident reported to Police Station: ☐ Yes ☐ No

n) Treatment Type: Medical ☐ Yes ☐ No Surgical – ☐ Yes ☐ No

o) Kindly Provide name and address of diagnostic centre in India where regular health check-up/investigations carried out

p) Provide name of medicine you were taking prior to departure from India:

q) Indicate other Travel/Health insurance coverage's, including name, address, policy number & certificate number of insurer:

**Details of Bills Enclosed:**

| Sl. No. | Details of Expenses Incurred | Amount (Currency) | Status of Payment Paid / Outstanding |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |

| | | | |
|---|---|---|---|
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |
| 11 | **Total** | | |

**4. Loss / Delay of Checked in Baggage:**

a) Describe when & where the loss/delay took place

b) State the extent of Loss:

c) Name the airline:

d) Flight Number: From: To:

e) Flight Number: From: To:

f) Have the airlines been notified at the time of loss? Yes No

g) Airline Reference No.:

h) Details of compensation received from airline:

i) Scheduled date/time of Arrival: D D M M Y Y Y Y H H M M

j) Actual date/time when bags delivered:

k) No. of Hours delayed:

| Sl. No. | Date | Details of Items / Expenses Incurred | Amount (Currency) | Place of Purchase |
|---|---|---|---|---|
| | | | | |
| | | **Total** | | |

**5. Loss of Passport / Identity Document Theft / Loss of Laptop/ Tablet / Hand baggage / Mobile/ Bail Bond/ Home Burglary/ Mugging Cover:**

a) Please provide details of the incident i.e. when, where and how it happened:

i. Date: D D M M Y Y Y Y Place:

ii. How: _____

_____

b) Details of Police Report – Number, Date and Place: _____

_____

| Sl. No. | Date | Details of Expenses Incurred | Amount (Currency) | Place |
|---|---|---|---|---|
| | | | | |
| | | **Total** | | |

**6. Trip Delay:**

a) Flight Number:

b) Date: D D M M Y Y Y Y From: To:

c) Scheduled date/time of Arrival: D D M M Y Y Y Y H H M M

d) Actual Date: D D M M Y Y Y Y

e) Number of Hours Delayed:

f) Reason for Delay:

| Sl. No. | Date | Details of Expenses Incurred | Amount (Currency) | Place |
|---|---|---|---|---|
| | | | | |
| | | **Total** | | |

**7. Trip Cancellation / Interruption:**

a) Flight Number:

b) Date: D D M M Y Y Y Y From: To:

c) Scheduled Time of Departure: H H M M

d) Reason for Cancellation:

| Sl. No. | Date | Details of Expenses Incurred | Amount (Currency) | Place of Purchase |
|---|---|---|---|---|
| | | | | |
| | | **Total** | | |

**8. Personal Liability:**

a) Please provide details of injury/property damaged

b) Have you received a court order: ☐ Yes ☐ No

**9. Emergency Hotel Accommodation/ Extension / Parent Accommodation / Hotel Cancellation:**

a) Please provide details of the Emergency Incident:

| Sl. No. | Date | Details of Expenses Incurred | Amount (Currency) | Place |
|---|---|---|---|---|
| | | | | |
| | | **Total** | | |

**10. Bounce Booking / Political Risk and Catastrophe Evacuation:**

a) Flight Number:

Date: D D M M Y Y Y Y From: To:

b) Common Carrier Details

Date: D D M M Y Y Y Y From: To:

c) Accommodation Details:

Date: D D M M Y Y Y Y From: To:

Place:

| Sl. No. | Date | Details of Expenses Incurred | Amount (Currency) | Place |
|---|---|---|---|---|
| | | | | |
| | | **Total** | | |

**11. Sponsor Protection:**

a) Please provide details of the incident/ accident i.e. when, where and how it happened:

i. Date: D D M M Y Y Y Y Place:

ii. How: _____

_____

b) Details of Police Report – Number, Date and Place: _____

_____

| Sl. No. | Date | Details of Expenses Incurred | Amount (Currency) | Place |
|---|---|---|---|---|
| | | | | |
| | | **Total** | | |

**12. Missed Connection:**

a) Flight Number:

b) Date: D D M M Y Y Y Y From: To:

c) Actual Date of Departure: D D M M Y Y Y Y Time of Departure: H H M M

d) Number of Hours Delayed:

**13. Missed Carrier:**

a) Please provide details of the Emergency Incident:

b) Flight Number:

c) Date: D D M M Y Y Y Y From: To:

d) Actual Date of Departure: D D M M Y Y Y Y Time of Departure: H H M M

e) Scheduled Date of Arrival: D D M M Y Y Y Y Time of Arrival: H H M M

f) Actual Time of Arrival: H H M M

g) Number of Hours Delayed:

| Sl. No. | Date | Details of Expenses Incurred | Amount (Currency) | Place |
|---|---|---|---|---|
| | | | | |
| | | **Total** | | |

**14. Daily Allowance/ Maternity Cash Benefit:**

a) Diagnosis:

b) Date of Admission: D D M M Y Y Y Y

c) Date of Discharge: D D M M Y Y Y Y

d) Hospital Name:

e) Place:

**15. Hijack Distress Allowances:**

a) Flight Number:

b) Date: D D M M Y Y Y Y From: To:

c) Scheduled Date of Departure: D D M M Y Y Y Y Time of Departure: H H M M

d) Scheduled Date of Arrival: D D M M Y Y Y Y Time of Arrival: H H M M

e) Date of Hijack: D D M M Y Y Y Y Time of Hijack: H H M M

f) Date of Returned: D D M M Y Y Y Y Time of Returned: H H M M

g) Please provide details of incident:

**16. Emergency Home Visit / Compassionate Visit / Replacement of Staff / Return of Minor/ Study Interruption:**

a) Please provide details of the Emergency Incident:

| Sl. No. | Date | Details of Expenses Incurred | Amount (Currency) | Place |
|---|---|---|---|---|
| | | | | |
| | | **Total** | | |

**17. Reimbursement of Golf Fees and Other Non-Transferable Ticket Expenses/ Up-gradation to Business Class:**

a) Details of Treatment or Injury:

b) Diagnosis:

c) Date of Admission: D D M M Y Y Y Y

d) Date of Discharge: D D M M Y Y Y Y

e) Hospital Name:

f) Place:

| Sl. No. | Date | Details of Expenses Incurred | Amount (Currency) | Place |
|---|---|---|---|---|
| | | | | |
| | | **Total** | | |

**18. Details of Policyholder's Bank Account**

This details needs to be furnished with cancelled cheque on the same account:

a) Bank Name.

b) Branch Name:

c) Bank Account Number

d) IFSC Code e) MICR No.

[Please attach copy of a cancelled blank cheque of your bank for ensuring accuracy of name of the Bank, Branch name, Account number and IFSC code. If name of the policyholder is not printed on the cheque please attach copy of the first page of the bank passbook/copy of bank statement also]

**19. Declarations:**

I/We hereby warrant that:
(1) I have read and understood the policy terms, conditions and exclusions
(2) The foregoing particulars are true and complete in all material respects.
(3) 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, suppression or concealment of 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 Assistance Provider / Insurance Company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim.

Date: D D M M Y Y Y Y

Place:

Signature of the Insured/ Policyholder/ Nominee

- This form must be signed and dated in all applicable sections.
- The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the company, nor a waiver of any of the terms and conditions of the insurance contract
- Please answer all questions completely. In case of insufficient space, please attach an additional sheet.
- Please attach all Original bills & receipts pertaining to your claim.

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| GUIDANCE FOR FILLING CLAIM FORM | | |
|---|---|---|
| **DATA ELEMENT** | **DESCRIPTION** | **FORMAT** |
| **1. DETAILS OF PRIMARY INSURED / CLAIMANT** | | |
| a) Insurance Certificate Number | Enter the certificate number | As allotted by the insurance company |
| b) Name of Insured / Corporate | Enter the Full Name of the company | Complete Name of Company |
| c) Name of Employee | Enter the Full Name | First Name , Middle Name, Surname |
| d) Name of Claimant | Enter the Full Name | First Name , Middle Name, Surname |
| e) Contact Number Overseas | Enter the Phone Number | Include ISD code with telephone number |
| f) Permanent Address | Enter the Full Postal Address | Include Street, City, State and Pin Code |
| g)Telephone Number | Enter the Phone Number of Policyholder | Include STD code with telephone number |
| h) E-mail Address | Enter E-mail Address of Policyholder | Complete E-mail Address |
| i) Date of Birth | Enter Date of Birth of Policyholder | Use DD/MM/YYYY format |
| j) Passport Number | Enter Passport Number | Complete Number |
| k) Date of Departure | Enter Date of Departure | As mentioned on your ticket |
| l) Date of Arrival | Enter Date of Arrival | As mentioned on your ticket |
| l) Claim Intimation Reference Number | Enter Claim Reference Number | Complete Number |
| **2. DETAILS OF BENEFIT TO BE AVAILED** | | |
| Please Indicate and Tick the Benefits claimed | | |
| **3. to 17. Details of Bills Enclosed** | | |
| Please fill in details of bills enclosed as per Benefits availed | | |
| **18. DETAILS OF POLICYHOLDERS BANK ACCOUNT** | | |
| a) Bank Name | Enter the Bank Name | Name of the Bank in full |
| b) Bank Branch | Enter Name of the Branch | Name of the Branch |
| c) Bank Account Number | Enter the Bank Account Number | As allotted by the Bank |
| d) IFSC Code | Enter the IFSC Code of the Bank Branch | IFSC Code of the Bank Branch in full |
| e) MICR Code | Enter the MICR Code | MICR Code of the Bank Branch in full |
| **19. DECLARATION** | | |
| Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. and stamp | | |

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