KOTAK GROUP SMART TRAVEL
Claim Form

24-25/V1

Part 1

Guidelines for completion of the Claims form

1. Claim Form consists of two parts –
   Part 1- General Information
   Part 2– Coverage as per Annexure
2. Please fill the Part 1 – General Information along with the relevant annexure page as per the Coverage opted for.
3. Issuance of this claim form is not to be taken as an admission of liability.
4. Please answer all questions completely. In case of insufficient space, please attach an additional sheet.
5. Please attach all Original bills & receipts pertaining to your claim.
6. Please fill & take the print out of only the relevant annexure pages.

SECTION 1 - DETAILS OF INSURED

1	Policy Number		
2	Insurance Certificate Number		
3	Claim Reference No, if any		
4	Passport Number		
5	Policy Start Date		Policy End Date
6	Name of the Insured Person / Corporate (in whose name the policy is issued)		
7	Name of the Claimant Person / Employee (in respect of whom the claim is made)		
8	Employee ID		
9	Email ID		
10	Contact Numbers (INDIA)		
11	Date of Birth		
12	Contact Numbers (Overseas)		
13	Residential Address (INDIA)		

SECTION 2 – TRIP DETAILS

Trip Destination		
Trip Details		
Date of Departure	DD/MM /YYYY	
Flight No.	_____ From	To
Date of Arrival	DD/MM /YYYY	
Flight No.	_____ From	To

*Every claim has to be accompanied with original ticket/ boarding pass or copy of the passport indicating the travel dates.

DECLARATION BY INSURED

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 hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish to the company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records, a photostat copy of this authorization shall be considered as effective and valid as the original.

Date: D D M M Y Y Y Y

Place:

Signature of the Insured

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DIRECT FUND TRANSFER / EFT MANDATE FORM

- Payee name (as per bank records) .....
- Payee account no .....
- Type of account: Saving ☐ Current ☐ Others ☐
- Name of the bank.....
- Branch Name.....
- Address of the bank: .....
- IFSC Code of the bank.....
- MICR code of the Bank.....
- PAN of the payee: .....

Please attach an **Original Blank Cancelled Cheque** signed by the payee. (Mandatory)

Please attach a **PAN Card** copy of Payee (mandatory)

Terms and Conditions for Payments through RTGS / NEFT

1. The details provided by the Customers in the Mandate Form shall be considered as final and Kotak Mahindra General Insurance Company Ltd. shall not be responsible for cross verification of any of the details provided therein.
2. The RTGS / NEFT facility shall be effective for the respective Customer(s) within 15 days of the receipt of the Mandate Form by Kotak Mahindra General Insurance Company Ltd. and/ or within such period as may be reasonably required by Kotak Mahindra General Insurance Company Ltd to activate the RTGS/ NEFT facility.
3. The Customer agrees that under the RTGS/ NEFT facility, there may be a risk of non-payment in the Account of Customer on the day of the credit of Payments due to change in the applicable regulations pertaining to RTGS/ NEFT facility or due to any other reasons without any fault/inaction/failure on part Kotak Mahindra General Insurance Company Ltd or any factor beyond the control of Kotak Mahindra General Insurance Company Ltd.
4. The Customer agrees to indemnify, without delay or demur, Kotak Mahindra General Insurance Company Ltd. and its agents and keep Kotak Mahindra General Insurance Company Ltd. and its agent indemnified harmless at all times from and against any and all claims, damages, losses, costs, and expenses (including attorney's fees) which Kotak Mahindra General Insurance Company Ltd. may suffer or incur, directly or indirectly, arising from or in connection with, amongst other things, either of the aforesaid reasons stated in above clauses.
5. Kotak Mahindra General Insurance Company Ltd. may sub-contract and employ agents to carry out any of its obligations under the RTGS/ NEFT facility. The Customer may discontinue or terminate the use of RTGS / NEFT facility by giving a minimum of 15 days prior written notice to Kotak Mahindra General Insurance Company Ltd. The date of notice for Kotak Mahindra will be the date of receipt of such notice by Kotak Mahindra. The notice of such termination should be given to Kotak Mahindra only at its corporate address and be addressed at Kotak Mahindra GIC Ltd, 27 BKC, C 27, G Block, Bandra Kurla Complex, Bandra (East), Mumbai 400051.
6. A confirmation of the receipt of termination notice given by the Customer will be acknowledged through a confirmation letter by Kotak Mahindra General Insurance Company Ltd. In no case can the Customer construe his termination notice as effective unless a confirmation has been provided by Kotak Mahindra to the Customer stating the date of receipt of such communication by the Customer.
7. The Customer agrees that transaction(s) through RTGS/ NEFT facility may attract inward RTGS/ NEFT charges, which if levied by the Customer's bank, shall be borne by the Customer
8. Kotak Mahindra has the absolute discretion to amend or supplement any Terms and Conditions stated herein at any time and will endeavour to give prior notice of Ten days for such changes wherever feasible for the terms and conditions to be applicable. By using the new services, or at the completion of such period, whichever is earlier, the Customer shall be deemed to have accepted the changed terms and conditions.
9. Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company.
10. Notices under these terms and conditions may be given in writing by delivering them by hand or e-mail or on Kotak Mahindra General Insurance Company Ltd. website www.kotakgeneral.com or by sending them by post to the last address of the Customer.
11. These terms and conditions will be governed by the laws of India and any legal action or proceedings arising out of these Terms and Conditions shall be initiated in the courts or tribunals in India.
12. I / We further undertake to refund any excess amount whether demanded by Kotak Mahindra General Insurance Company Ltd. or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from the Company of such excess credit or such information of excess credit coming to the knowledge of the Customer through any other source.

    I/ We agree that my/our claim payment will be credited from the date Kotak Mahindra General Insurance Company Ltd. gets confirmation from its bankers, this facility will continue unless it is revoked by any party and any issuance of relevant credit instruction from Kotak Mahindra General Insurance Company Ltd. to its bankers will be valid till such instruction is complete irrespective of the fact that the notice period has expired provided such a credit request has been made by Kotak Mahindra General Insurance Company Ltd. before the expiry of the notice period of the customer

Signature of the Policy Holder/ Insured/ Nominee

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Part 2 – Annexure 1

MEDICAL COVERS

Nature of Injury/sickness	
Details of incidence	
Diagnosis and Treatment given	
When did patient's symptoms first appear	
Describe any other disease or infirmity affecting present condition	
Out Patient Treatment	☐ ☐
Hospitalization	☐ ☐
Out-patient Care	
Nature of Injury/sickness	
Details of incidence	
Diagnosis and Treatment given	
When did patient's symptoms first appear	
Describe any other disease or infirmity affecting present condition	
Out Patient due to	1) Pregnancy ☐ 2) Illness ☐ 3) Injury ☐
Is illness due to any pre-existing condition	Yes ☐ / No ☐
If Injury, give cause	1) Self Inflicted
	2) Road Traffic Accident
	3)Substance Abuse/Alcohol Abuse
Medico Legal	Yes ☐ / No ☐
Reported to Police	Yes ☐ / No ☐
MLC report attached	Yes ☐ / No ☐
Hospitalization	
Is Hospitalization due to	1) Pregnancy ☐ 2) Illness ☐ 3) Injury ☐
Is illness due to any pre-existing condition	Yes ☐ / No ☐
If Injury, give cause	1) Self Inflicted
	2) Road Traffic Accident
	3)Substance Abuse/Alcohol Abuse
Medico Legal	Yes ☐ / No ☐
Reported to Police	Yes ☐ / No ☐
MLC report attached	Yes ☐ / No ☐

Sr. No.	Details of treatment / expenses	Date	Expenses in Foreign Currency
1			
2			
3			
4			
Total			

Medical Evacuation	
Reason for Evacuation	
Please detail out the above reason for evacuation (How, Where, When and reason for the same)	
Evacuation Date	DD/MM /YYYY
Original Travel Dates	From: DD/MM /YYYY HH:MM To: DD/MM /YYYY HH:MM

Details of Losses/Expenses Incurred:		
Sr. No.	**Loss/Expense Details**	**Amount**
1		
2		
3		
4		
Total		

Repatriation of Mortal Remains	
Cause / Circumstances of death	
Date of death of insured	DD/MM /YYYY
Evacuation Date	
Original Travel Dates	From: DD/MM /YYYY HH:MM To: DD/MM /YYYY HH:MM

Details of expenses incurred for repatriation of Remains / Funeral:			
Sr. No.	**Details of expenses**	**Date (dd/mm/yyyy)**	**Expenses in Foreign Currency**
1			
2			
3			
4			
Total			

Dental Expenses	
Nature of Ailment	
State Diagnosis and nature of treatment taken	
Dates of treatment	From: DD/MM /YYYY To: DD/MM /YYYY
Date of onset of symptoms	DD/MM /YYYY
Name, address & telephone number of consulting physician/dentist/ hospital where treatment was taken	
Have you ever been treated for this illness before	Yes ☐ / No ☐
If yes, provide name, address & telephone number of consulted physician	
Provide name, address & telephone number of your family / regular doctor in India	

Sr. No.	**Details of treatment / expenses**	**Date**	**Expenses in Foreign Currency**
1			
2			
3			
4			
Total			

Attending Doctor's Report (for sickness/accident /dental claim type)	
Name of the Patient and Age	
Date of accident/ Sickness	
Details of the insured's injury/ sickness	
When did patient's symptoms first appear	
Diagnosis and nature of treatment provided	
Was the ailment due to Pregnancy	Yes ☐ / No ☐
Was the ailment aggravated due to any pre-existing condition?	Yes ☐ / No ☐
If yes, please give details	
Name of the attending Physician	
Address	
Phone no	

Date: D D M M Y Y Y

Place:

Signature of the attending Physician with Stamp

Compassionate Visit – Travel, Compassionate Visit - Emergency Hotel Accommodation / Extension	
Treating Doctor's opinion on how many more days the patient will need to be hospitalized	
Treating Doctor's opinion on why the patient cannot be sent back to Country of Residence of the Insured Person for further treatment	
Treating Doctor's opinion on need for an attendant	
Name of the Attendant/ Staff	

Sr. No.	Details of treatment / expenses	Date	Expenses in Foreign Currency
1			
2			
3			
4			
Total			

Sports Injury/ Illness (Adventure and/ or Professional Sports)	
Details of Sport	
Event Organizer details	
Date of Incident	
Claim amount	DD/MM /YYYY

Home to Home Cover	
1. Incidence of claim description	
2. Date of loss and Place of loss	
3. Claim amount	
Kindly fill the details of respective section (Medical expenses Accident and Illness, Medical Expenses – Accident Only and Personal Accident section)	

Lifestyle Support

Sr. No.	Details of expenses	Date	Amount
1			
2			
3			
4			
Total			

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Date: D D M M Y Y Y

Place:

Claimant's/ Insured's Signature

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TRAVEL COVERS

Loss of Checked-in Baggage (Indemnity)	
Loss of Checked-in Baggage (Benefit)	
Delay of Checked-in Baggage (Indemnity)	
Delay of Checked-in Baggage (Benefit)	
Delay of Checked-in Baggage-Round Trip (Indemnity)	
Delay of Checked-in Baggage - Round Trip (Benefit	
Name the common carrier	
Flight Details	
Flight No	From: DD/MM /YYYY HH:MM To: DD/MM /YYYY HH:MM
Flight No	From: DD/MM /YYYY HH:MM To: DD/MM /YYYY HH:MM
Place of Delay / Loss	
Actual Date & Time of Arrival of flight at Port	DD/MM /YYYY HH:MM
Actual Date & Time when Bags were delivered	DD/MM /YYYY HH:MM
No. of Hours of bag delay	
Had the common carrier been notified at the time of loss?	Yes ☐ / No ☐
Property Irregularity Report (PIR) number from Airline/ Common Carrier	
Details of compensation received from carrier	

Sr. No.	Items Lost	Date of Purchase	Cost in Foreign Currency (In INR for loss claim)
1			
2			
3			
4			
Total			

Trip Delay	
Trip Delay due to Natural Calamity / Terrorism (Benefit)	
Trip Delay (Indemnity)	
Reason for Trip Delay	
Please detail out the reason for trip delay (how, where, when, what was lost and reason for the same)	
Original Travel Dates	From: DD/MM /YYYY To: DD/MM /YYYY
Trip delayed on	DD/MM /YYYY
No. of Hour's delay	
Person affected and relationship with the Insured (If not the Insured, please also provide address and contact details)	

Details of Expenses Incurred:

Sr. No.	Loss / Expenses Details	Amount
1		
2		
3		
4		
Total		

Trip Cancellation (Before commencement of Trip)	
Trip Interruption / Trip Curtailment (Cutting short of Trip)	
Trip Curtailment	☐ ☐
Trip interrupted	☐ ☐
Trip Cancelled	☐ ☐
Reason for Trip Cancellation/ Trip Interruption/ Curtailment	
Please detail out the above reason for trip cancellation / interruption (how, where, when and reason for the same)	
Trip Cancellation / Interruption date	DD/MM /YYYY
Original Travel Dates	From: DD/MM /YYYY To: DD/MM /YYYY
Person affected and relationship with the Insured (If not the Insured, please also provide address and contact details)	

Details of Expenses Incurred:		
Sr. No.	**Loss / Expenses Details**	**Amount**
1		
2		
3		
4		
Total		

Hotel Over Booking	
Reason for Bounced Booking	
Please detail out the reason for the Bounced Booking (how, where, when and reason for the same)	
Original Travel/ Accommodation Dates	From: DD/MM /YYYY HH:MM To: DD/MM /YYYY HH:MM
Days on which the booking was bounced	

Details of Expenses Incurred:		
Sr. No.	**Loss / Expenses Details**	**Amount**
1		
2		
3		
4		
Total		

Missed Connection (Benefit)	
Missed Connection (Indemnity)	
Original Travel Schedule (Please give date and time of all common Carrier, mentioning the original and actual arrival and departure times. Please also mention the name of carriers or flight numbers)	
Which common Carrier was delayed causing a missed connection?	
Reason for delay of the Common Carrier	

Details of Expenses Incurred:		
Sr. No.	**Expenses Details**	**Amount**
1		
2		
3		
4		
Total		

Hijack Distress Allowance	
Name of Common Carrier	
Port of Hijack	
Port of Release	
Dates & Time of Hijack	From: DD/MM /YYYY HH:MM To: DD/MM /YYYY HH:MM

Loss of Passport (Indemnity)	
Loss of Passport (Benefit)	
Identity Document Theft/Loss	
Date of loss of passport/ international driving license/ Visa/ Temporary Permit	DD/MM /YYYY HH:MM
Place of loss of passport/ international driving license / Visa/ Temporary Permit	

Expenses incurred in obtaining new passport/ international driving license/ Visa/ Temporary Permit:

Details of Expenses Incurred:		
Sr. No.	**Expenses Details**	**Amount**
1		
2		
3		
4		
Total		

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Date: D D M M Y Y Y

Place:

Claimant's/ Insured's Signature

OTHER COVERS

Personal Liability	
Date of Loss	DD/MM /YYYY HH:MM
Place of Loss	
Please provide details of injury / property damaged	
Name of aggrieved Third Party	
Amount of Liability	

SECTION 3 C – ACCIDENT COVER

3.C.1 Personal Accident ☐	
3.C.2 Personal Accident Common Carrier ☐	
Please state circumstances of accident i.e. how, when, where it took place	
Nature of Injury	
State diagnosis and nature of treatment / surgery under taken	
Provide name, address & telephone number of Hospital / Clinic	
Treating Doctor's Name & Qualifications	
Treating Doctor's Telephone Number	(O) (M)
Room / Ward / Bed Number	
Dates of treatment	From: DD/MM /YYYY To: DD/MM /YYYY
Attending Doctor's Report	DD/MM /YYYY HH:MM
Date doctor contacted	
Nature of Ailment	
State diagnosis and nature of treatment provided	
Describe any other disease or infirmity affecting present condition	
Was the accident due to Pregnancy	Yes ☐ / No ☐
Was the accident due to any pre-existing condition	Yes ☐ / No ☐
If yes, please give details	
Can the patient be evacuated back to the Republic of India?	Yes ☐ / No ☐
Loss Incurred (Please tick)	☐ Death
	☐ Permanent Total Disability:
	(Details)
	☐ Permanent Partial Disability:
	(Details)

3.C.3 Child Education Cover	
Name of child	
Educational Institution name	

Details of Expenses Incurred:		
Sr. No.	**Expenses Details**	**Amount**
1		
2		
3		
4		
Total		

3.C.4 Modification of Residence / Vehicle			
Sr. No.	**Details of Expenses**	**Date**	**Amount**
1			
2			
3			
4			
Total			

SECTION 3 D – OTHER COVERS

3.D.1 Personal Liability	
Date of Loss	DD/MM /YYYY
Place of Loss	
Please provide details of injury / property damaged	
Name of aggrieved Third Party	
Amount of Liability	

3.D.2 Debit/ Credit Card/ Forex Card - Fraud	
Details of Card(s) lost	
Place and address where the loss took place	
Place, address and time at which the Card(s) were last seen by Insured	
Date and time when the loss was first discovered	
State the circumstances of the loss or damage in detail	
List of transactions post loss of card	

Card Number	**Date/Time of Transaction**	**Place of Transaction**	**Transaction Value**

Date and time of reporting the loss to Police Station. (Please furnish copy of FIR)	
Date and time of reporting the loss to the Card issuing authority	
Location and branch of Card issuing authority from where the Card(s) was issued	
Is there any other insurance on the same card(s)? If so, give full particulars	
Any other information relevant to processing of claim	

Home Burglary Fire and Allied Perils (Buildings and Contents)	
Address of property where loss was sustained	
Date of Loss	DD/MM /YYYY
Cause of Loss	
Exact description of nature of loss and it causes (in case of burglary, how was forceful entry gained into the premises and who is suspected of the same)	
Has the loss been reported to the proper authorities?	Yes ☐ / No ☐
Please give details of where and to whom the loss has been reported along with the date and time (If not reported, please give reasons for the same)	
Details of any other insurance cover for the property	

Details of Loss Incurred:		
Sr. No	**Items lost due to fire / burglary**	**Amount**
1		
2		
3		
4		
Total		

Visa Rejection / Denial Insurance Visa Cost Cover	
Reason for Visa Denial	
Trip Details	

Sr. No.	**Expenses Details**	**Amount**
1		
2		
3		
4		
Total		

Return of Minor Child	
In the Event of Hospitalization	
Person Hospitalized	☐ ☐ Insured ☐ ☐ Family Member
Name of the person hospitalized (if not the insured)	
Relationship with the insured	
Provide name, address & telephone number of Hospital / Clinic	
Treating Doctor's Name & Qualifications	
Treating Doctor's Telephone Number	(O) (M)
Room / Ward / Bed Number	
Dates of hospitalization	From: DD/MM /YYYY HH:MM To: DD/MM /YYYY HH:MM
Date of onset of symptoms	DD/MM /YYYY
In case of death of the Insured	
Cause/ Circumstances of death	
Date of death of Insured	
Attending Doctor's Report	
Date doctor contacted	DD/MM /YYYY HH:MM
Nature of Ailment	
State diagnosis and nature of treatment provided	
When did patient's symptoms first appear?	
Describe any other disease or infirmity affecting present condition	
Was the ailment due to Pregnancy	Yes ☐ / No ☐
Was the ailment aggravated due to any pre-existing condition?	Yes ☐ / No ☐

Return of Minor Child	
If yes, please give details	
Can the patient be evacuated back to the Republic of India?	Yes ☐ / No ☐
Estimated time the patient would continue to be in hospital?	
Is Medical Evacuation back to Republic of India needed?	Yes ☐ / No ☐
Please give detailed reasons of the ailment and reason for transportation	
Medical Doctor's Signature and Date	

Details of Expenses			
Sr. No	**Details of Expenses**	**Date**	**Amount**
1			
2			
3			
4			
Total			

Pet Care (Domestic)	
1. Incidence of claim description	
2. Place of loss	
3. Date of loss	
4. Claim amount	

Event Cancellation	
Event Name	
Event Date & Time	
Event Cancellation Reason	

Sr. No.	Details of Expenses	Date	Amount
1			
2			
3			
4			
Total			

Sports Equipmentt Cover	
1. Incidence of claim description	
2. Rental amount (Excluding deposit)	
3. Is Incident notify by the respective authority?	
4. Date of loss and Place of loss	
5. Claim amount	

Rental Excess Insurance	
1. Incidence of claim description	
2. Is Incident notify by the respective authority?	
3. Date of loss and Place of loss	
4. Claim amount	

Golfer's Hole in one	
1. Name of the Tournament	
2. Date of Tournament	
3. Claim amount	

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Loss of Personal Belongings		
1	Date of loss of Personal belongings / Baggage	DD/MM /YYYY HH MM
2	Place of loss of Personal belongings / Baggage	

Sr. No.	Details of Expenses	Date	Amount
1			
2			
3			
4			
Total			

Piste Closure		
1.	Incidence of claim description	
2.	Place of loss	
3.	Date of loss	
4.	Piste closure duration	
5.	Claim amount	

Up-gradation to Business Class			
1.	Details of Journey	From: DD/MM /YYYY	To: DD/MM /YYYY
2.	Date of Journey		
3.	Expense amount		

Political Risk and Catastrophe Evacuation			
1.	Reason for Evacuation		
2.	Please detail out the above reason for Evacuation (how, where, when and reason for the same):		
3.	Evacuation date		
4.	Original Travel date	From: DD/MM /YYYY	To: DD/MM /YYYY
5.	Claim amount		

Details of Losses/Expenses Incurred:		
Sr. No	**Loss/Expense Details**	**Amount**
1		
2		
3		
4		
Total		

Automatic Extension			
1.	Reason for Trip delay		
2.	Please detail out the reason for trip delay (how, where, when, what was lost and reason for the same):		
3.	Original Travel date	From: DD/MM /YYYY	To: DD/MM /YYYY
4.	Trip delayed on		

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Date: D D M M Y Y Y

Place:

Claimant's/ Insured's Signature

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CLAIMS NOT FALLING IN THE ABOVE-MENTIONED SECTIONS

Type of claim:		
Incidence of claim description:		
Place of loss:	Date of loss: DD/MM /YYYY	Claimed amount:
Claim Number:	Policy Number:	

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Date: D D M M Y Y Y

Place:

Claimant's/ Insured's Signature

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