RELIANCE
General Insurance

1800 3002 8282 (toll free)
022 3989 8282 (charges apply)
www.reliancegeneral.co.in

Reliance Travel Care Insurance Policy
Claim Form

Claim No.
For the office use only

Certificate/ Policy No. | Period From | Period To

Details of Insured

(To be filled in BLOCK LETTERS)

Name of the Insured ☐ Mr. ☐ Ms.

Address for Communication

Flat Building

Road/Street/Sector

Area

Taluka/Village/District/City | Pin Code

State | Country

Phone | Mobile

Email | Fax

Relationship of the Patient/Insured Person with the Insured ☐ Self ☐ Spouse ☐ Son ☐ Daughter

Details of Patient/Insured Person

(To be filled in BLOCK LETTERS)

Name of the Patient/Insured Person ☐ Mr. ☐ Ms.

Date of Birth d d m m y y y y | Sex : ☐ M ☐ F

Address for Communication

Flat Building

Road/Street/Sector

Area

Taluka/Village/District/City | Pin Code

State | Country

Phone | Mobile

Email | Fax

Claim Details

Has the Emergency Assistance Service Provider been intimated ? ☐ Yes ☐ No

If yes, please provide the reference number | Passport No.

Please indicate whether claim is in respect of

☐ Medical Expenses	☐ Dental Care Expenses	☐ Repatriation /Evacuation	☐ Compassionate Visit
☐ Personal Accident	☐ Accidental Death & Dismemberment-Common Carrier		☐ Loss of checked Baggage
☐ Delay of checked Baggage	☐ Loss of Passport	☐ Trip Delay	☐ Trip Cancellation / Interruption
☐ Missed Connection	☐ Hijack Distress Allowance	☐ Personal Liability	☐ Financial Emergency Assistance
☐ Sponsor protection	☐ Study interruption	☐ Bail Bond	☐ Home Burglary

Important Guidelines :

1 **Issuance of the form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract.**
2 **Please answer all questions completely. In case of insufficient space, please attach an additional sheet.**
3 **Please attach all bills, receipts, credit card slips pertaining to your claim.**
4 **No claim under Accident & Sickness Section will be admitted without Doctor's Report as per format.**
5 **Failure to call our Emergency Assistance Service Provider shall invalidate your claim,**

Authorization

I Hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited, I further declare that, in respect of the above statement, no benefits are admissible under any other Medical scheme or Insurance. 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 _____

Place _____

_____
Signature of Insured Person

Reliance General Insurance Co. Ltd. **Registered Office** 19, Reliance Centre, Walchand Hirachand Marg, Ballard Estate, Mumbai 400 001

An ISO 9001:2008 Certified Company

RELIANCE
General Insurance

reliancegeneral.co.in
1800 209 55 22

Reliance Travel Care Insurance Policy
Claim Form A

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 d d m m y y y y

2. **In case of accident**

   Please provide the details of the accident _____

   _____

   Please provide the cause of the accident _____

   _____

   Date of the accident d d m m y y y y

   Place of the accident _____

3. Please specify whether the Patient/Insured person was hospitalized for treatment of disease/illness/injury: ☐ Yes ☐ No

   If yes, period of Hospitalization/
   Treatment done for disease/illness/injury: From d d m m y y y y To d d m m y y y y

4. Nature of Treatment done for disease/illness/injury _____

   _____

5. Name of the Hospital/Nursing Home where treatment of the disease/illness/injury was given: _____

   _____

6. Address
   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. _____

8. Address
   Flat/Building/Door/Block No. _____
   Road/Street/Sector _____
   Area _____
   Taluka/Village/District/City _____ Pin Code _____
   State _____ Country _____
   Telephone No. _____ Mobile _____
   Email _____ Fax _____

In case of a claim under any of the add-on benefits, please fill in the following details
(Applicable only if the Insured Person has opted for the additional add-on benefits under the Student Plan)

Sr. No.	Coverage	Total Expenses
1.	Treatment of Mental and Nervous Disorders including Alcohol and Drug Dependency	
2.	Impatient Hospitalization expenses related to Pregnancy/Child birth.	
3.	Medical Expenses for Inter collegiate sports injuries.	
4.	Cancer Screening and Mammographic Examinations.	
5.	Child Care Benefits	
6.	Chiropractic Treatment	
7.	Physiotherapy Treatment	
8.	Skilled Nursing Treatment	

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

_____

c. Name of the Consulted Physician: Dr. _____

d. Address of the Consulted Physician

Flat/Building/Door/Block No. _____

Road/Street/Sector _____

Area _____

Taluka/Village/District/City _____ Pin Code _____

State _____ Country _____

Fax _____

e. Telephone Number of the Consulted Physician _____

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

Detail of Expenses	In/Out Patient From	To	Charges (Currency)	Rupees
			Paid	
			Outstanding	
			Total Due	

f. Family Physicians Name _____

Contact No. _____ Email Id _____

g. Regular Dentist Name _____

Contact No. _____ Email Id _____

Repatriation of Remains/Emergency Evacuation

9. Date of Departure [d d m m y y y y] 10. Date of Arrival [d d m m y y y y]

11. Flight No. [ ] From _____ To _____

12. **In case of a claim for emergency evacuation:**

Cause of disease/illness/injury leading to evacuation: _____

Date of injury or commencement of disease/illness: [d d m m y y y y] Place _____

13. **In case of a claim for repatriation of remains/funeral expenses:**

Cause of Death _____

Date of Death [d d m m y y y y] Place of Death _____

14. 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)

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

Name ☐ Mr. ☐ Mrs. [ ]

Age [ ] yrs Sex ☐ M ☐ F

Address
Flat/Building/Door/Block No. [ ]

Road/Street/Sector [ ]

Area [ ]

Taluka/Village/District/City [ ] Pin Code [ ]

State [ ] Country [ ]

Fax [ ] Email Id: [ ]

Phone No. [ ]

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

_____

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

_____

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

_____

19. **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 _____

_____

20. **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 d d m m y y y y to d d m m y y y y

Name of Hospital/ Nursing Home where treatment of the disease/illness/injury was given:

Address
Flat/Building/Door/Block No.

Road/Street/Sector

Area

Taluka/Village/District/City Pin Code

State Country

Fax

Name of the attending Doctor/Physician Dr.

Address
Flat/Building/Door/Block No.

Road/Street/Sector

Area

Taluka/Village/District/City Pin Code

State Country

Telephone No. Mob. No.

Fax Email ID

Date: d d m m y y y y

Attending Doctor's/Physician's Signature

Place: _____

Compassionate Visit

21. Please specify the details of the disease/illness/injury: _____

_____

_____

22. Date of accident/onset of ailment:

23. Was the Patient/Insured Person hospitalized? ☐ Yes ☐ No

24. Period of Hospitalization: From d d m m y y y y To d d m m y y y y

25. Please provide the details of the treatment given: _____

_____

_____

26. Please provide the following details of the Hospital/Nursing Home where the treatment for disease/illness/injury was taken:

Name of the Hospital/ Nursing Home

Address
Flat/Building/Door/Block No.

Road/Street/Sector

Area

Taluka/Village/District/City | Pin Code

State | Country

Telephone No. | Mob. No.

Fax | Email ID

27. 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 _____

_____

28. In the opinion of the treating doctor, how many days of hospitalization would the Patient/Insured Person require?

29. In the opinion of the treating doctor, is there a need for an attendant for the Patient/Insured Person: _____

_____

30. **Please fill in the following details, only in case the Patient/Insured Person has opted for the Reliance Travel Care Insurance Policy-Student Plan**

Please specify as to who has been hospitalized: ☐ Patient/Insured Person ☐ Immediate family member of the Insured Person

Name of the family member hospitalization: _____

Relationship with the Patient/Insured Person: _____

RGI/MCOM/CO/HL-06/CF/VER. 1.1/300316

RELIANCE GENERAL INSURANCE
A RELIANCE CAPITAL COMPANY

reliancegeneral.co.in
1800 209 55 22

Reliance Travel Care Insurance Policy
Claim Form B

Personal Accident/Accidental Death & Dismemberment-Common Carrier

1. **Details of Accident**

When did the accident happen? _____ am/pm

Date of death d d m m y y y y Time of death _____ am/pm

Location _____

Please provide the necessary details about the accident _____

_____

Please state the nature and extent of loss _____

_____

Please state the amount claimed _____

2. **Details of Witnesses**

Witness 1

Name ☐ Mr. ☐ Mrs. _____

Address for communication
Flat/Building/Door/Block No. _____

Road/Street/Sector _____

Area _____

Taluka/Village/District/City _____ Pin Code _____

State _____ Country _____

Telephone No. _____ Mob. No. _____

Email ID _____ Fax _____

Witness 2

Name ☐ Mr. ☐ Mrs. _____

Address for communication
Flat/Building/Door/Block No. _____

Road/Street/Sector _____

Area _____

Taluka/Village/District/City _____ Pin Code _____

State _____ Country _____

Telephone No. _____ Mob. No. _____

Email ID _____ Fax _____

3. **Treatment Details**

Please specify whether the Insured Person was hospitalised for the treatment of injury due to the accident? ☐ Yes ☐ No

If yes, period of Hospitalisation From d d m m y y y y To d d m m y y y y

Please provide name of the Hospital/Nursing home where the Insured Person was treated for the injury sustained due to the accident?

_____

IRDAI Registration No. 103. Reliance General Insurance Company Limited. Registered Office: H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai - 400710. **Corporate Office:** Reliance Centre, South Wing, 4th Floor, Off. Western Express Highway, Santacruz (East), Mumbai - 400 055. Corporate Identity Number U66603MH2000PLC128300. Trade Logo displayed above belongs to Anil Dhirubhai Ambani Ventures Private Limited and used by Reliance General Insurance Company Limited under License. RGI/MCOM/CO/HL-06/CF/VER. 1.2/120517.

Address for communication
Flat/Building/Door/Block No.

Road/Street/Sector

Area

Taluka/Village/District/City | Pin Code

State | Country

Telephone No. | Fax

Please provide the name of Physician/Surgeon who attended the Insured Person during the treatment for the injury sustained due to the accident?

Address for communication
Flat/Building/Door/Block No.

Road/Street/Sector

Area

Taluka/Village/District/City | Pin Code

State | Country

Telephone No. | Mob. No.

Email ID | Fax

Have the Police Authorities been informed about this accident?

Have the following documents, been submitted?

a. Copy of FIR ☐ Yes ☐ No

b. Death Certificate ☐ Yes ☐ No

c. Police Report ☐ Yes ☐ No

d. Post Mortem Report (in case of accident death) ☐ Yes ☐ No

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

Name of Insured Person

Age ____ yrs

Address
Flat/Building/Door/Block No.

Road/Street/Sector

Area

Taluka/Village/District/City | Pin Code

State | Country

Phone | Mobile

Email | Fax

Please state nature of the accident and details of injuries sustained

Does the cause of accident as stated by the Insured Person tally with the injuries noticed by you?

Are the injuries solely due to the accident or traceable to any previous injuries/disease/infirmities?

Was the Insured Person suffering from any disease/injury which may have contributed to the accident or likely to aggravate his/her condition.

Was the Insured Person hospitalized? If so for what period? From d d m m y y y y To d d m m y y y y

Please provide the details of treatment given and operations performed, if any?

Was he/she under the influence of intoxicants or drugs at the time of accident?

Has this accident been reported to the police authorities? If yes

Case No. Police Station

Name of Attending Doctor/Physician Dr.

Address
Flat/Building/Door/Block No.

Road/Street/Sector

Area

Taluka/Village/District/City Pin Code

State Country

Telephone No. Mobile

Fax Email ID

Date d d m m y y y y

Attending Doctor/Physician's Signature

Regn. No.

RELIANCE GENERAL INSURANCE
A RELIANCE CAPITAL COMPANY

reliancegeneral.co.in
1800 209 55 22

Reliance Travel Care Insurance Policy
Claim Form C

Name of the common carrier _____

Flight No. _____ From: d d m m y y y y To: d d m m y y y y

Please complete the section relevant to your claim

Loss of Total Checked Baggage

1. Nature of Claim ☐ Loss ☐ Delay
2. Date d d m m y y y y Time _____ hrs Location _____
3. Number of pieces of baggage checked-in _____
4. Number of pieces of baggage lost/delayed _____
5. In case of baggage, please specify the following

   Scheduled date of Arrival d d m m y y y y Scheduled time of Arrival _____ hrs

   Actual date of Arrival d d m m y y y y Actual time of Arrival _____ hrs

   Number of Hours delayed _____

   (Please provide the details of expenses related to the loss of the checked baggage in the table given below)

Loss of Passport

6. Date d d m m y y y y Time _____ hrs Location _____
7. Passport number _____
8. Please provide the details of the incident _____
9. Please provide the details of the Police Report _____
10. (Please attach a copy of the Police Report): Reference No. _____

    Date d d m m y y y y Location _____

    (Please provide the details of expenses related to the loss of Passport & the checked baggage in the table given overleaf)

Loss of International Driving License and Travel Documents

11. Date d d m m y y y y Time _____ hrs Location _____
12. Driving License No. _____
13. Ticket/Boarding Pass No. _____
14. Please provide the details of the incident _____
15. Please provide the details of the Police Report _____
16. (Please attach a copy of the Police Report): Reference No. _____

    Date d d m m y y y y Location _____

    (Please provide the details of expenses related to the loss of International Driving License & Travel Documents in the table given overleaf))

IRDAI Registration No. 103. Reliance General Insurance Company Limited. Registered Office: H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai - 400710. **Corporate Office:** Reliance Centre, South Wing, 4th Floor, Off. Western Express Highway, Santacruz (East), Mumbai - 400 055. Corporate Identity Number U66603MH2000PLC128300. Trade Logo displayed above belongs to Anil Dhirubhai Ambani Ventures Private Limited and used by Reliance General Insurance Company Limited under License. RGI/MCOM/CO/HL-06/CF/VER. 1.2/120517.

Trip Delay/Cancellation/Interruption/Missed Connection

17. **Reason for Trip delay/Cancellation/Interruption**

- ☐ Death or Unforeseen disease/illness/injury
- ☐ Termination of Employment
- ☐ Inclement Weather Conditions
- ☐ Abduction/Quarantine of the Insured Person
- ☐ Terrorist Incident in the place of visit
- ☐ Delay of Common Carrier*
- ☐ Lost or stolen passport, travel documents or money.*
- ☐ Felonious Assault on the Insured Person/Family Member/Traveling Companion
- ☐ Uninhabitable condition of the place of stay abroad due to fire, flood, vandalism, burglary, or natural disaster

* Not applicable for trip delay

18. The person affected ☐ Insured Person ☐ Immediate Family Member of the Insured Person ☐ Traveling Companion

19. **If the person affected is not the Insured Person, please provide the following details**

Name of the person affected

Address
Flat/Building/Door/Block No.

Road/Street/Sector

Area

Taluka/Village/District/City Pin Code

State Country

Fax

Relationship with the Insured Person _____

20. **In case of trip delay and missed connection**

Scheduled date of Arrival (d d m m y y y y) Scheduled time of Arrival hrs

Actual date of Arrival (d d m m y y y y) Actual time of Arrival hrs

Number of Hours delayed

21. **In case of missed connection**

Date of Departure of Connecting Flight (d d m m y y y y) Time hrs

22. **In case of trip cancellation/trip interruption**

Date (d d m m y y y y) Time hrs

Location

23. Whether accommodation & boarding provided by the carrier? ☐ Yes ☐ No

Detail of Expenses incurred	Date	Place	Cost
		Total	
		Less Compensation received from the airline	
		Net Amount	

*In case of Delay, please provide details of the purchases made _____

*In case of Loss, please provide details of the items lost _____

Hijack Distress Allowance

24. Place of Hijack _____ Date (d d m m y y y y) Time hrs

25. Place of Release _____ Date (d d m m y y y y) Time hrs

26. Please provide the necessary details of the incident _____

Personal Liability

27. Please provide the name of third party injured, if applicable _____

28. Please provide the details of injury/property damaged _____

_____

29. Please provide the details of the court award _____

_____

30. Please specify the details of amount claimed _____

_____

31. Date of Loss d d m m y y y y Place of Loss _____

32. Any other information you would like us to have: _____

_____

Financial Emergency Assistance

33. Date of Loss d d m m y y y y Time _____ hrs

34. Reason for Loss: _____

Please fill in the following details, only if the insured person has opted for the Reliance Travel Care Insurance Policy-Student Plan

Bail Bond

35. Name of the Detaining Authority _____

36. Address
Flat/Building/Door/Block No. _____
Road/Street/Sector _____
Area _____
Taluka/Village/District/City _____ Pin Code _____
State _____ Country _____
Fax _____

37. Please specify the offense for which the Insured Person has been detained: _____

38. Is the offense bailable as per the law of the country? ☐ Yes ☐ No
Please specify the relevant details _____
Please specify the bail amount _____

Sponsor Protection

39. Name of the Sponsor _____

40. Please specify the cause of the accident causing the demise of the Sponsor: _____

_____

41. Please describe the nature of the injury causing the demise of the Sponsor: _____

_____

42. Place of the accident _____ 43. Date of accident d d m m y y y y

44. Name of the University _____

45. Course Duration _____

46. Tuition fees payable by the Student for the remaining duration _____

Study Interruption

47. Reason for study interruption: ☐ Hospitalization of the Insured Person ☐ Death of the Immediate Family Member/Sponsor of the Insured Person

48. In case of Hospitalization of the Insured Person
Please provide the details of the disease/illness/injury _____

_____

Please provide the cause of the disease/illness/injury _____

_____

49. Date of accident or onset of disease/illness [d d m m y y y y] Place _____

50. Name of Hospital/Nursing Home where treatment of the disease/illness/injury was given

51. Address
Flat/Building/Door/Block No.

Road/Street/Sector

Area

Taluka/Village/District/City Pin Code

State Country

Fax

52. Period of Hospitalization From [d d m m y y y y] to [d d m m y y y y]

53. Has the Insured Person been advised to be evacuated on medical grounds back to India? ☐ Yes ☐ No

54. If yes, please specify the reason for the evacuation _____

55. **In case of Death of the Immediate Family Member/Sponsor of the Insured Person**

Name of the Immediate Family Member/Sponsor of the Insured Person: _____

Relationship of the Immediate Family Member/Sponsor with the Insured Person _____

Please specify the cause of the accident causing the demise of the Immediate Family Member/Sponsor _____

Please describe the nature of the injury causing the demise of the Immediate Family Member/Sponsor _____

56. Place of accident _____ 57. Date of accident [d d m m y y y y]

58. Tuition fee payable by the Student for the remaining duration: _____

Loss or Damage to Business Equipment

59. Date of Loss [d d m m y y y y] 60. Location of Loss _____

61. Description of Loss _____

62. Cause of Loss _____

63. Details of the Business Equipment Delayed/Lost/damaged

Sr. No.	Items	Nature of Loss	Hire/Purchase/Courier Expenses	Amount

64. In case of theft, has this incident been reported to the Police Authority? ☐ Yes ☐ No

65. In case of delay, whether the Common Carrier was notified? ☐ Yes ☐ No

Alternative Employee or Resumption of Assignment Expenses

59. Date of Loss [d d m m y y y y] 60. Nature of Loss _____

61. Cause of Loss _____

a. Traveling expense towards deployed person

b. Return Travel expenditure towards Insured/Insured Person

RELIANCE GENERAL INSURANCE
A RELIANCE CAPITAL COMPANY

reliancegeneral.co.in
1800 209 55 22

Reliance Travel Care Insurance Policy
Claim Form D

Please return the completed form within fourteen days of the loss together with the relevant vouchers, documents etc.

Home Burglary

1. Address of the premises at which the loss occured.
   Flat/Building/Door/Block No. _____
   Road/Street/Sector _____
   Area _____
   Taluka/Village/District/City _____ Pin Code _____
   State _____ Country _____
   Telephone No. _____ Fax _____
2. How was the said premises occupied?
   _____
3. Date of loss [d d m m y y y y] 4. Time of loss [ ] hrs.
5. When was the loss first discovered add by whom? _____
6. Please state as to how the entry to/exit from the premises effected? _____
7. Please specify the portion of the premises which was affected by the entry or exit? _____
8. Please provide details as to how the loss occurred _____
   _____
9. Has a complaint been lodged with the Police Authorities? ☐ Yes ☐ No
   If yes,
   a) Who lodged the complaint with the Police Authorities?
   _____
   b) Which Police station was the complaint lodged at?
   _____
   c) When was the complaint lodged? Please attach a copy of the Police complaint. _____
   (Note: If this is not done, this may be done immediately and a copy thereof be submitted)
10. Please state the total value of property upon the premises at the time of loss
    _____
11. Please state whether the property is covered under a Fire and Special Perils Policy? ☐ Yes ☐ No
    if yes
    a) Please state the Sum Insured applicable _____
    b) Name(s) of the Insurer(s). _____

    Is there any other Insurance against the present loss under any other Policy? ☐ Yes ☐ No

    If yes, please give full particulars _____

IRDAI Registration No. 103. Reliance General Insurance Company Limited. Registered Office: H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai - 400710. **Corporate Office:** Reliance Centre, South Wing, 4th Floor, Off. Western Express Highway, Santacruz (East), Mumbai - 400 055. Corporate Identity Number U66603MH2000PLC128300. Trade Logo displayed above belongs to Anil Dhirubhai Ambani Ventures Private Limited and used by Reliance General Insurance Company Limited under License. RGI/MCOM/CO/HL-06/CF/VER. 1.2/120517.

Declaration

I/We hereby declare that the foregoing particulars are true and correct in every respect and that the articles and property described belong to the person/s named, no other person having any interest therein, whether as Owner, Mortgagee, Trustee or otherwise.

Details of Articles Stolen. (In case of insufficient space, please attach a separate sheet.)

Date d d m m y y y y

Place

Signature of Insured Person