

Reliance Travel Care Insurance Policy Claim Form

Claim No.
For the office use only

Certificate/ Policy No.	Period From	Period To
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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 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

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

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

