

CANCELLING YOUR TRIP/ CUTTING YOUR TRIP SHORT

Flight No. _____ Date ____/____/____ From _____ to _____
 Scheduled time of Departure: _____ Cause for Cancellation / Cutting your trip short : _____

Details of Expense incurred*	Date	Place	Amount
Amt refunded by Common Carrier/Tour Operator/Hotel			
		TOTAL	

Additional Travelling Cost for return (In case of Cutting short your trip)

Proof of travel cost/invoice as well as refund allowed by the airlines/hotel/tour operator.

****Please note that this coverage applies if Trip is cancelled/you have to cut short your trip due to illness, injury or death to: You; Your Traveling Companion; Your Immediate Family Member.***

MEDICAL AND OTHER EXPENSES

Details of illness/injury i.e. how, when, where it took place: _____

Date: _____ Place: _____

Name & Address of consulting physician: _____

Have you ever been treated for this condition before: Yes No

If yes, provide name & address of consulted physician: _____

Provide name & address of your treating physician: _____

Provide name of any prescription medicine you are presently taking: _____

Indicate other health insurance coverages, including name, address, policy number & certificate number of insurer: _____

DETAILS OF MEDICAL EXPENSES & OTHER EXPENSES

Details of treatment	In/ Out Patient		Charges	Status of Payment
	From	To		Paid/ Outstanding
				Paid
				Outstanding
			TOTAL	

AUTHORIZATION

I hereby declare that I have suffered injuries / loss as described above and all the details given are ABSOLUTELY TRUE AND CORRECT.
 I hereby agree to forfeit all my rights to compensation if any of the foregoing facts and / or details are found to be false or incorrect.
 I further authorise the hospital, doctor diagnostic laboratory, organisation, establishment or any other body or person dealt with in the course of this claim to give any information or document sought for by the Insurance Company.

Signature of insured : _____

Attending Doctor's Report

Patient's Name: _____ Age: _____ Sex: M / F

Address: _____

Date contacted: _____ Time: _____

Nature of Illness/Injury: _____

X-Ray Taken: s No Date taken: _____

Diagnosis and Treatment Given: _____

Describe any other disease or infirmity affecting present condition: _____

Signature: _____

Attending Doctor's Signature

**NOTE : 1. This form along with the documents to be sent at the above address.
2. For claim under benefits not mentioned on the Claim form, you may please get in touch with us at Contact Nos. mentioned for case direction.**