JetProtect Domestic Travel Claim Form

Claimant's Name: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Claimant's Address: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Phone No. (Mobile): |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| Phone No. (Res): |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Email ID: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Policy start date: D|D|M|M|Y|Y|Y|Y| Policy end date: D|D|M|M|Y|Y|Y|Y|

In what capacity are you making this claim? ____

☐ Hospitalization Expenses for Injury

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: D|D|M|M|Y|Y|Y|Y| To: D|D|M|M|Y|Y|Y|Y|

Date of onset of symptoms: D|D|M|M|Y|Y|Y|Y|

Attending Doctor's Report

Date doctor contacted: D|D|M|M|Y|Y|Y|Y| Time: H|H|M|M

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

If yes, please give details: ______________________________

Can the patient be evacuated back to the Republic of India? ☐ Yes ☐ No

Medical Doctor's Signature and Date: ______________

☐ Repatriation of Remains

Cause / Circumstances of death: _____

Date of death of insured: D|D|M|M|Y|Y|Y|Y|

Details of expenses incurred for repatriation of Remains / Funeral:

Sr. No.	Details of treatment/expenses	Date	Expenses in Foreign Currency / INR

Please attach the Photocopy of the death certificate providing the details of the place, date and time, and the circumstances and cause of the death (photocopy of the postmortem certificate wherever required by the Assistance Service Provider), issued by the appropriate authority where the contingency has arisen, and further provide the proof for expenses incurred towards disposal of the mortal remains, and In case of transportation of the body of the deceased to the Country of Residence of the Insured, the receipt for expenses incurred towards preparation and packing of the mortal remains of the deceased and also for the air transportation of the mortal remains of the deceased to the Country of Residence of the Insured.

☐ Checked-In Baggage Loss/Delay:

Describe when & where the Loss / Delay took place: _____

State the extent of Delay / Loss: _____ Place of Delay / Loss: _____

Name the common carrier: _____ No. of Hours of bag delays: _____

Flight Details:

1. Flight No.: From: _____ To: _____
2. Flight No.: From: _____ To: _____

Actual Date & Time of Arrival of flight at Port: D|D|M|M|Y|Y|Y|Y| H|H|M|M

Actual Date & Time when Bags were delivered: D|D|M|M|Y|Y|Y|Y| H|H|M|M

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.	Item Purchased / Items Lost	Date of Purchase	Cost in Foreign Currency (In INR for loss claim)
Total			
Compensation from Airline			
Net Amount			

Documents to be submitted in support of the claim for Checked-in Baggage Loss:

1. Statement of claim furnishing the details of items contained in the Checked-In Baggage.
2. Property irregularity report issued by the Common Carrier.
3. Voucher of the Common Carrier for the compensation paid for the non-delivery / short delivery of the Checked-In Baggage.

4. Copies of correspondence exchanged, if any, with the Common Carrier in connection with the non-delivery / short delivery of the Checked-In Baggage.

In case of compensation from the Common Carrier having been received after payment of the claim by the Company hereunder, the Insured shall repay to the Company such amount in excess of his / her loss after taking into account the amount of claim received from the Company and at that received from the Common Carrier.

In case the undelivered Checked-In Baggage is subsequently traced by the Common Carrier and offered for delivery to the Insured, the Insured shall take delivery of the Checked-In Baggage and refund the amount paid by the Company hereunder. In case of delivery of part of the Checked-In Baggage, the amount paid by the Company attributable to such Checked-In Baggage shall be refunded by the Insured to the Company.

Documents to be submitted in support of the claim Checked-in Baggage Delay:

1. Property irregularity report stating the scheduled time of delivery and actual time of delivery of the Checked-In Baggage issued by the Common Carrier;
2. Voucher of the Common Carrier for the compensation paid for the delay in delivery of the Checked-In Baggage;
3. Copies of correspondence exchanged, if any, with the Common Carrier in connection with the delay in delivery of the Checked-In Baggage.

☐ Personal Accident

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 D|D|M|M|Y|Y|Y|Y| To: D|D|M|M|Y|Y|Y|Y|

Attending Doctor's Report

Date doctor contacted: D|D|M|M|Y|Y|Y|Y| Time: H|H|M|M

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) _____

Medical Doctor's Signature and Date:

Please attach medical reports giving the details of the Accident, nature of Injury and the extent of disability, in case of death of the Insured, death certificate issued by the Medical Practitioner who attended on the insured, and the postmortem certificate to be produced Further attach the police report in original in case the accident shall have taken place in a public place or premises.

☐ Trip Cancellation and Interruption

☐ Trip cancelled / ☐ Trip interrupted ☐ Also claiming for Trip Regained

Reason for Trip Cancellation /Interruption: _____

_____

Please detail out the above reason for trip cancellation / interruption (how, where, when and reason for the same):

Trip Cancellation / Interruption date: D|D|M|M|Y|Y|Y|Y|

Original Travel Dates: From: D|D|M|M|Y|Y|Y|Y| To: D|D|M|M|Y|Y|Y|Y|

Person Affected and Relationship with the Insured: (If not the Insured, please also provide address and contact details)

_____

_____

Details of Losses / Expenses Incurred:

Sr. No.	Loss / Expenses Details	Amount

Documents to be submitted in support of the claim:

1. In case of cancellation of the Trip either in the City of Residence of the Insured or any other intermediate place forming part of the Trip by the Common Carrier solely resulting from contingencies namely Earthquake, Storm, Flood, inundation, cyclone, tempest & Terrorism, fog (if specifically covered) duly completed claims form to be accompanied by:

    a) Confirmation of cancellation of the Trip from the Common Carrier detailing the circumstances of cancellation;
    b) Original used air ticket indicating the cost the ticket and receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the Trip the cancellation charges retained;
    c) Original bill and a receipt / letter obtained from the hotel and / or guest house and / or any other paid residential accommodation (available for fee) indicating the amount paid for the accommodation, the refund given and the cancellation charges retained, wherever such accommodation has be arranged at the place of cancellation of the Trip;
    d) Used air ticket in original for return journey from the place of cancellation to the City of Residence of the Insured which indicate the cost of the tickets together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip.

2. In case the cancellation of the Trip shall result because of personal contingencies covered hereunder or a decision taken at the instance of the Insured arising out of the contingencies namely Earthquake, Storm, Flood, inundation, cyclone, tempest & Terrorism, fog (if specifically covered) the duly completed claims form to be accompanied by:

    a) A declaration from the Insured furnishing the circumstances that compelled him / her to cancel the Trip;
    b) Medical evidence as may be required by the Assistance Service Provider in case of the cancellation of the Trip arising out of personal contingencies of the Insured or his / her Immediate Family;
    c) Receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the Trip indicating the cancellation charges retained;
    d) Receipt / letter obtained from the for the hotel and / or guest house and / or any other residential accommodation (available for a fee) indicating the cancellation charges retained, wherever such accommodation has be arranged at the place of cancellation of the Trip;

e) Used air ticket or boarding pass in original for return journey from the place of cancellation to the City of Residence of the Insured together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip

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3. In case the cancellation charges either for the Trip or part of it or in relation to the accommodation in a hotel / guest house / other residential accommodation is waived to the advantage of the Insured subsequent to any settlement of claim under this Benefit, the Insured shall forthwith return the sum paid by the Company to the extent of such waiver.

☐Trip Delay

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: D|D|M|M|Y|Y|Y|Y| To: D|D|M|M|Y|Y|Y|Y|

Trip delayed on: D|D|M|M|Y|Y|Y|Y|

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

Please attach confirmation of delay of the Trip from the Common Carrier detailing the circumstances of delay, in case of delay of the Trip, at any places forming part of the Trip, by the Common Carrier solely resulting from contingencies namely earthquake, storm, flood, inundation, cyclone, tempest & terrorism, fog (if specifically covered)

☐ Compassionate Visit

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: D|D|M|M|Y|Y|Y|Y| To: D|D|M|M|Y|Y|Y|Y|

Date of onset of symptoms: D|D|M|M|Y|Y|Y|Y|

Attending Doctor's Report

Date doctor contacted: D|D|M|M|Y|Y|Y|Y| Time: H|H|M|M

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

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 the hospital? _____

Medical Doctor's Signature and Date: _____

Expenses Details

Sr. No.	Details of expenses	Date	Expenses in Foreign Currency / INR

Please attach a certificate from the Medical Practitioner recommending the presence in the form of special assistance to be rendered by a member of the Family or near relative during the entire period of Hospitalization. Certificate to also specify the minimum period of Hospitalization and discharge summary of the Hospital furnishing details – date of admission, date of discharge, and the presence of the member of the Family or near relative on all days of Hospitalization original ticket used for the travel to and fro by the member of the Family or near relative.

☐ Home Insurance

Address of property where loss was sustained:

Date of Loss: D|D|M|M|Y|Y|Y|Y|

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): _____

Occupants of the premises at the time of loss / by who were it discovered: _____

Has the loss been reported to the proper authorities? 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

Documents to be submitted in support of the claim

1. First Information Report
2. Panchnama
3. Investigation Report by the Police
4. The statement of claim furnishing the details of items lost and the values thereof duly supported by purchase bills wherever available. In the event of the purchase bills not being available, he / she shall render such evidence as may be required by the surveyor for the latter to arrive at the value of the lost items.
5. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy.

For any claim related to/on account of any Accident or Personal Liability

Please describe the incident: _____
Date of Injury: D|D|M|M|Y|Y|Y|Y|
Are you Attorney represented for this Injury? Yes/No if yes, complete below:
Attorney Name: _____ Law Firm Name: _____
Phone: _____ Address: _____

☐ **Vehicular Accident**
Type of Vehicle:_____

☐Single Vehicle Accident ☐ Multiple Vehicle Accident
Vehicle Insurance Information for patient:
Driver Name:_____
Policyholder Name:_____
Insurance Co. Name:_____
Address:_____
_____
Adjuster's Name:_____
Adjuster's Phone:_____
Claim Number:_____

Did you rent a car? ☐Yes ☐ No
If yes, Owner (Rental Company):_____
Location of Rental:_____
Important! Please provide a copy Rental Receipt and/or Agreement.
Vehicle Insurance Information for Other Party:
Driver Name:_____
Policyholder Name:_____
Insurance Co. Name:_____
Address:_____
_____
Adjuster's Name:_____
Adjuster's Phone:_____
Claim Number:_____

☐ **Premises Injury**
Homeowner or Business Name:_____
_____
Address:_____
_____
Phone:_____
Insurance Co. Name:_____
Address:_____
_____
Adjuster's Name:_____
Adjuster's Phone:_____
Claim Number:_____

☐ **Product Injury**
Product Name:_____
Company Name:_____
Insurance Co. Name:_____
Address:_____
_____
Adjuster's Name:_____
Adjuster's Phone:_____
Claim Number:_____

☐**Other Injury**
Please describe (Attach separate sheet if necessary)
_____
_____
_____
_____

I/We hereby agree, affirm and declare that:

1. The statements/ information given/ stated by me/ us in this claim form are true, correct and complete.
2. The details of all people having an interest in the property in respect of which the claim is being made are provided as per the proposal form or by way of an endorsement in the policy. Furthermore, save and except as provided or disclosed in

this claim form, no claim made hereunder (or the same/ similar claim) has been made or lodged with any other insurance company.

3. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.
4. If I/we have given/ made any false or fraudulent statement/ information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I/ We shall not be entitled to all/ any rights to recover hereunder in respect of any or all claims, past, present or future.
5. The receipt of this claim form/ other supporting/ related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/ additional information and documents in respect of the claim.
6. I do hereby authorize International Subrogation Management (ISM) to inquire and obtain any information regarding my accident. Further, ICICI Lombard is hereby authorized to release any and all information, including copies of pertinent documents, which ISM may deem necessary in order to satisfy their inquiry, If during the investigation, ISM has identified a potential recovery source, allowing the Plan Participant's employer to recover paid benefits, ISM is authorized to release any all records they deem necessary in order to pursue the recovery.

Place: _____
Date: _____ Signature of the claimant _____

All information received as a result of this release will not be disseminated to any other entity without the expressed written authorization of the Plan participant, or The Member, if the Participant is a minor. This authorization is valid for one year from the date of signature.

*Please read the policy wordings for detailed requirements of documents ICICI Lombard General Insurance Company Ltd. Insurance is the subject matter of the solicitation MISC 110