THE NEW INDIA ASSURANCE CO. LTD.

Regd. & Head Office: New India Assurance Bldg., 87, Mahatma Gandhi Road, Fort, Mumbai - 400 001.

CLAIM FORM FOR OVERSEAS MEDICLAIM POLICY

(To be submitted at the nearest office of American Assist Travel Services)

(FOR ADDRESSES SEE POLICY DOCKET)

Name of Persons Claiming: Mr. / Mrs.
Home Address in India:

Occupation: Date _____ Time _____ Tel. No.

DETAILS OF CERTIFICATE C.O. CODE D. O. CODE PLAN CATEGORY

Certificate No.

SERIAL NUMBER

Date - Policy Issued

Date - Trip Commenced

No. of Days

Scheduled Date of Return

Geographical Limits	Worldwide Excl. USA & CANADA	Worldwide Include USA & CANADA

NAME AND AGE OF EACH PERSON INCLUDED IN THE CLAIM

Mr./Mrs./Miss.	Initials	Surname	Date of Birth Day Month Year

POLICY SECTION RELATING TO CLAIM (Tick Boxes)

Personal Accident

Medical Expenses

Loss of Passport

Loss of Checked in Baggage Personal Effects

Delay of Checked Baggage

Personal Liability

DATE OF CLAIM OCCURRENCE: TRIP DESTINATION

PLEASE COMPLETE APPROPRIATE SECTION OF CLAIM FORM AND READ CAREFULLY THE INSTRUCTIONS RELATING TO SUPPORTING DOCUMENTS REQUIRED. WHEN COMPLETED PLEASE SIGN DECLARATION:

I Declare that to the best of my knowledge all particulars contained in this form are true. I also authorize American Assist Travel Services to obtain may medical records or information necessary to process the claim.

Signed: Date: Place:

MEDICAL AND EMERGENCY EXPENSES / HOSPITAL BENEFIT/ PERSONAL ACCIDENT (INCLUDING ADDITIONAL TRAVEL, ACCOMMODATION EXPENSE)

I) DOCUMENTS REQUIRED:

The following documents must be enclosed with your completed claim from

- ORIGINAL CERTIFICATE OF INSURANCE TOGETHER WITH ANY
- COPIES OF AIRLINE TICKETS
- ORIGINAL BILLS OR RECEIPTS FOR FULL AMOUNT OF CLAIM (PHOTOCOPIES NOT ACCEPTABLE)
- CONFIRMATION BY HOSPITAL OF DATES OF HOSPITALISATION (FOR CLAIMS FOR HOSPITAL BENEFITS)
- DEATH CERTIFICATE (FOR COMPENSATION CLAIMS OF DEATH BY ACCIDENT)
- THE MEDICAL CERTIFICATE DOES NOT NEED TO BE COMPLETED FOR MINOR ACCIDENS OR. ILLNESS
- PHYSICIAN'S REPORT (ORIGINAL ATTACHED TO THE POLICY OF APPLICABLE).

These documents must be supplied with the completed claim form at the Claimant's expense. Failure to do so will delay the processing of your claim and could result in it being declined.

I) TO BE COMPLETED BY THE CLAIMANT OR THE CLAIMANTS LEGAL REPRSENTATIVE:

1) Name of Sick or Injured Person:
2) Nature of Injury / Illness:
3) Date of Injury / Illness:
4) Place of Injury / Illness:
5) Circumstances of Injury:
6) If claim was due to hospitalization or curtailment, was the Emergency Assistance Departmental contacted YES/NO. If not, please advice, why, on an additional information Sheet.
7) Dates of Hospitalization: From To:
8) Details of Claim:
9) Details of any third parties involved in accidental injury or death of insured person.
10) Details of Private Health Insurance
11) a) Name of Insurer:
    b) Address of Insurer:
    c) Policy Number:
    d) Telephone Number:

Details of Claimed Expense, Providers Name, Prescription Charges, etc.	Amount Charged in Local Currency	IMPORTANT Has Bill Been Paid by You*
		YES / NO
		YES / NO
		YES / NO
		YES / NO
		YES / NO
		YES / NO
		YES / NO
TOTAL AMOUNT		*Delete where Applicable

BAGGAGE, PERSONAL EFFECTS
(INC. BAGGAGE DELAY)

I) DOCUMENTS REQUIRED:

ORIGINAL CERTIFICATE OF INSURANCE (PHOTOCOPIES NOT ACCEPTABLE UNLESS AN ANNUAL POLICY

AIRLINE TICKETS

ANY AVAILABLE RECEIPTS FOR THE LOST BAGGAGE IF UNAVAILABLE SUPPLY ANY OTHER DOCUMENTATION WHICH COULD ASSIST IN GIVING PROOF OF VALUE, eg. VALUATIONS, SALES LITERATURE, ETC.

ORIGINALS OF ALL WRITTEN REPORTS RECEIVED FROM CARRIER IF VERBAL REPORTS ONLY WAS MADE PLEASE SPECIFY.

PLEASE SUPPLY PROPERTY IRREGULARITY REPORT AND COPIES OF YOUR CORRESPONDENCE WITH THE AIRLINE.

IF CLAIM IS FOR DELAYED BAGGAGE, PLEASE SUPPLY PROPERTY IRREGULARITY REPORT AND LETTER FROM CARRIER CONFIRMING REASON FOR DELAY AND DURATION OF THE DELAY.

THESE DOCUMENTS MUST BE SUPPLIED WITH THE COMPLETED CLAIM FORM AT THE CLAIMANT'S EXPENSE, FAILURE TO DO SO WILL DELAY THE PROCESSING OF YOUR CLAIM AND COULD RESULT IN IT BEING DECLINED.

II) TO BE COMPLETED BY THE CLAIMANT OR THE CLAIMANT'S LEGAL PERSONAL REPRESENTATIVE.

1) Time, Date and Place of Loss / Delay :

2) Full Circumstances of Loss / Delay :

3) Loss / Delay occurred in the custody of an airline.

   a) Date reported to Carrier :

   b) Name and address of carrier

1) Name and Position of any other person in authority to whom the matter was reported.

2) Details of Household Contents or All Risks Policy or any other Policy in force which may cover this loss including Private Policy Travel Extension (THIS SECTION MUST NOT BE LEFT BLANK).

Name of Insurer:

Address:

Policy No.:

Tel. No.:

ADDITIONAL INFORMATION YOU MAY WISH TO GIVE IN SUPPORT OF YOUR CLAIM UNDER ANY SECTION OF THE POLICY

_____
_____
_____
_____

Once a claim becomes payable under the terms and conditions of the policy and any costs have been met by you or any person on your behalf please indicate below to whom you would like cheque payable and their full address:

Payee's Name:
Address:

Date:
Place: Signature:

ECS Details of the Insured

1	Name of the Insured (as appearing in the Bank Account)	
2	Bank Name	
3	Branch and address	
4	Bank Account No.	
5	Bank Account Type	
6	IFSC Code	
7	MICR Code	