Aditya Birla Health Insurance Company Ltd.

(A part of Aditya Birla Capital Ltd.)

ADITYA BIRLA CAPITAL

PROTECTING INVESTING FINANCING ADVISING

Activ Fit (Young Adult Product) - Travel Insurance

1. Details of the Primary Insured / Claimant:

a) Insurance Policy Number / Certificate Number:

b) Name of the Insured / Corporate:

c) Name of the Employee:

d) Name of Claimant:

e) Contact Number Overseas:

f) Permanent Address:

City: State: PIN:

g) Phone No – Mobile Home Work:

h) Email ID:

i) Date of Birth: D D M M Y Y Y Y

j) Passport Number:

k) Date of Departure: D D M M Y Y Y Y Flight Number: From: To:

l) Date of Arrival: D D M M Y Y Y Y Flight Number: From: To:

m) Claim Intimation Reference Number:

2. Benefit availed:

Sr No	Name of Benefit	Select	Sr No	Name of Benefit	Select
1	Loss of Check In Baggage		2	Delay of Checked-in Baggage	
3	Trip Cancellation & Interruption		4	Trip Delay	
5	Missed Connection		6	Flight Delay / Cancellation	

3. Details of Bills Enclosed:

Sr. No.	Details of Expenses Incurred	Amount (Currency)	Status of Payment Paid / Outstanding
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
	Total		

4. Loss / Delay of Checked in Baggage:

a) Describe when & where the loss/delay took place

b) State the extent of Loss:

c) Name the airline:

d) Flight Number: From: To:

e) Flight Number: From: To:

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f) Have the airlines been notified at the time of loss? ☐ Yes ☐ No

g) Airline Reference No.:

h) Details of compensation received from airline:

i) Scheduled date/time of Arrival: D D M M Y Y Y Y H H M M

j) Actual date/time when bags delivered:

k) No. of Hours delayed:

Sr. No.	Date	Details of Items / Expenses Incurred	Amount (Currency)	Place of Purchase
		Total		

5. Trip Cancellation / Interruption:

a) Flight Number:

b) Date: D D M M Y Y Y Y From: To:

c) Scheduled Time of Departure: D D M M Y Y Y Y H H M M

d) Reason for Cancellation:

Sr. No.	Date	Details of Expenses Incurred	Amount (Currency)	Place of Purchase
		Total		

6. Trip Delay:

a) Flight Number:

b) Date: D D M M Y Y Y Y From: To:

c) Scheduled date/time of Arrival: D D M M Y Y Y Y H H M M

d) Actual Date: D D M M Y Y Y Y

e) Number of Hours Delayed:

f) Reason for Delay:

Sr. No.	Date	Details of Expenses Incurred	Amount (Currency)	Place
		Total		

7. Missed Connection:

a) Flight Number:

b) Date: D D M M Y Y Y Y From: To:

c) Actual Date of Departure: D D M M Y Y Y Y Time of Departure: H H M M

d) Number of Hours Delayed:

Sr. No.	Date	Details of Expenses Incurred	Amount (Currency)	Place
		Total		

8. Flight Delay / Cancellation:

a) Please provide details of the Incident:

b) Flight Number:

c) Date: D D M M Y Y Y Y From: To:

d) Scheduled Date of Departure: D D M M Y Y Y Y Time of Departure: H H M M

e) Scheduled Date of Arrival: D D M M Y Y Y Y Time of Arrival: H H M M

f) Actual Time of Arrival: H H M M

g) Number of Hours Delayed:

Sr. No.	Date	Details of Expenses Incurred	Amount (Currency)	Place
		Total		

9. Details of Policyholder's Bank Account

This details needs to be furnished with cancelled cheque on the same account:

a) Bank Name.

b) Branch Name:

c) Bank Account Number

d) IFSC Code e) MICR No.

[Please attach copy of a cancelled blank cheque of your bank for ensuring accuracy of name of the Bank, Branch name, Account number and IFSC code. If name of the policyholder is not printed on the cheque please attach copy of the first page of the bank passbook/copy of bank statement also]

10. Declarations:

I/We hereby warrant that:
(1) I have read and understood the policy terms, conditions and exclusions
(2) The foregoing particulars are true and complete in all material respects.
(3) I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize Assistance Provider / Insurance Company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim.

Date: D D M M Y Y Y Y

Place:

Signature of the Insured/ Policyholder/ Nominee

- This form must be signed and dated in all applicable sections.
- The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the company, nor a waiver of any of the terms and conditions of the insurance contract
- Please answer all questions completely. In case of insufficient space, please attach an additional sheet.
- Please attach all Original bills & receipts pertaining to your claim.

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GUIDANCE FOR FILLING CLAIM FORM		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
1. DETAILS OF PRIMARY INSURED / CLAIMANT		
a) Insurance Certificate Number	Enter the certificate number	As allotted by the insurance company
b) Name of Insured / Corporate	Enter the Full Name of the company	Complete Name of Company
c) Name of Employee	Enter the Full Name	First Name , Middle Name, Surname
d) Name of Claimant	Enter the Full Name	First Name , Middle Name, Surname
e) Contact Number Overseas	Enter the Phone Number	Include ISD code with telephone number
f) Permanent Address	Enter the Full Postal Address	Include Street, City, State and Pin Code
g)Telephone Number	Enter the Phone Number of Policyholder	Include STD code with telephone number
h) E-mail Address	Enter E-mail Address of Policyholder	Complete E-mail Address
i) Date of Birth	Enter Date of Birth of Policyholder	Use DD/MM/YYYY format
j) Passport Number	Enter Passport Number	Complete Number
k) Date of Departure	Enter Date of Departure	As mentioned on your ticket
l) Date of Arrival	Enter Date of Arrival	As mentioned on your ticket
l) Claim Intimation Reference Number	Enter Claim Reference Number	Complete Number
2. DETAILS OF BENEFIT TO BE AVAILED		
Please Indicate and Tick the Benefits claimed		
3. to 8. Details of Bills Enclosed		
Please fill in details of bills enclosed as per Benefits availed		
9. DETAILS OF POLICYHOLDERS BANK ACCOUNT		
a) Bank Name	Enter the Bank Name	Name of the Bank in full
b) Bank Branch	Enter Name of the Branch	Name of the Branch
c) Bank Account Number	Enter the Bank Account Number	As allotted by the Bank
d) IFSC Code	Enter the IFSC Code of the Bank Branch	IFSC Code of the Bank Branch in full
e) MICR Code	Enter the MICR Code	MICR Code of the Bank Branch in full
10. DECLARATION		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. and stamp		

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