Chola MS
GENERAL INSURANCE

CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED | Registered Office: 2nd Floor, “DARE House”, 2, N.S.C. Bose Road, Chennai - 600 001.
Toll free: 1800 208 9100 | T: +91 (0) 44 4044 5400 | F: +91 (0) 44 4044 5550 | E: customercare@cholams.murugappa.com | website: www.cholainsurance.com
IRDAI Regn. No.123 | PAN: AABCC6633K | CIN: U66030TN2001PLC047977 | **REACH US THROUGH WHATSAPP** 7305234433

Emergency Assistance Details:
Europ Assistance India Pvt. Ltd.
Behind ITC Maratha Hotel, Sahar Road, Andheri East, Mumbai 400059, INDIA.
24 Hours Claims Assistance Nos. (TPA: Europ Assistance India Pvt. Ltd.,) - USA - 18337426674, Singapore, Thailand - 001 + 800 9944 1234, Japan - 001 / 010 + 800 9944 1234, Hong Kong - 001 / 006 + 800 9944 1234, Australia - 0011 + 800 9944 1234, Canada - 011 + 800 9944 1234, Israel - 00 / 014 + 8009944 1234, Greece - 86002038018, Argentina, Austria, Belgium, China, Czech Republic, Denmark, France, Germany, Hungary, Italy, Malaysia, Netherlands, New Zealand, Norway, Philippines, Poland, Portugal, South Africa, Spain, Sweden, Switzerland, Taiwan, United Kingdom - 00 + 800 99441234, All other countries (Non toll free number) - +91 22 6734 7848

CHOLA MS Travel - Claim Form

- The issuance of this form is not to be taken as an Admission of Liability.
- Please answer all questions completely. Use additional sheet, if required.
- Please attach the document required as indicated.
- Please note that the list of documents mentioned is an indicative list; the Insurer may ask for any other documents to process the claim.

DETAILS OF THE CLAIMANT		
Name of the Claimant		
Policy Number	Period of Insurance DDMMYYYY	TO DDMMYYYY
Address		
City	State	Pin Code
Telephone Number	Mobile Number	
Occupation	E-mail	
Relationship of claimant with the insured	Date of commencement of Trip	Date of Scheduled Return
ABHA I.D. No		

Section to which Claim pertains (Please tick whichever is applicable).	
☐ Medical Expenses (Medical Evacuation Included)	☐ Financial Emergency
☐ Medical Evacuation Repatriation of Mortal Remains	☐ Hospital Daily Cash
☐ Dental Treatment Expenses	☐ Hijack Relief
☐ Total Loss of Checked Baggage	☐ Trip Cancellation
☐ Delay of Checked-In Baggage	☐ Trip Curtailment
☐ Loss of Passport	☐ Trip Delay
☐ Loss of International Driving Licenses	☐ Emergency travel Expense-Replacement of colleague Abroad
☐ Personal Accident- Overseas	☐ Emergency Medical Expense (Accidental Hospitalization only with in India)
☐ Personal Liability	☐ Personal Accident - Domestic
If, Others Please specify:	

Disclaimer: The Company may contact you for matters related to your policy or to provide details of products & services offered. To opt out from the facility, please register under Do Not Call section on our website.

CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED | Registered Office: 2nd Floor, "DARE House", 2, N.S.C. Bose Road, Chennai - 600 001.
Toll free: 1800 208 9100 | T: +91 (0) 44 4044 5400 | F: +91 (0) 44 4044 5550 | E: customercare@cholams.murugappa.com | website: www.cholainsurance.com
IRDAI Regn. No.123 | PAN: AABCC6633K | CIN: U66030TN2001PLC047977 | **REACH US THROUGH WHATSAPP** 7305234433

1. MEDICAL EXPENSES

Please attach Doctor's reports, Original admission / discharge card, Original bills / receipts / with prescriptions and diagnostic / investigative reports, Copy of passport / visa with entry & exit stamp and copy of the ticket and boarding pass.

Name of the disease contacted					
When disease first manifested (Date)	DDMMYYYY	Date when treatment started	DDMMYYYY	Date when treatment ended	DDMMYYYY
Date of admission	DDMMYYYY	Date of discharge	DDMMYYYY		
Name of Treating Doctor			Name of Clinic / Hospital		
Address					
Contact number		Nature of Disease/Injury (Please describe briefly)			
Hospital expenses (Please show each head separately; please mention in US Dollars)					
Room Rent		Consultancy Charges		Cost of Treatment	
Other Costs		Outpatient Expenses		Total Claim Amount	

2. REPATRIATION OF REMAINS

If you are claiming for the extra costs of transportation home (for self and / or accompanying person), mortal remains or burial expenses, please provide following details.

Name of Airlines	Burial Details
Expenses Incurred	Other incidental costs with bifurcation of expenses

3. DENTAL TREATMENT EXPENSES

Please attach Doctor's reports, Original admission / discharge card, Original bills / receipts / with prescriptions and diagnostic / investigative reports, Copy of passport / visa with entry & exit stamp and copy of the ticket and boarding pass.

Name of the disease contacted					
When disease first manifested (Date)	DDMMYYYY	Date when treatment started	DDMMYYYY	Date when treatment ended	DDMMYYYY
Date of Admission		Date of Discharge	DDMMYYYY		

Disclaimer: The Company may contact you for matters related to your policy or to provide details of products & services offered. To opt out from the facility, please register under Do Not Call section on our website.

CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED | Registered Office: 2nd Floor, "DARE House", 2, N.S.C. Bose Road, Chennai - 600 001.
Toll free: 1800 208 9100 | T: +91 (0) 44 4044 5400 | F: +91 (0) 44 4044 5550 | E: customercare@cholams.murugappa.com | website: www.cholainsurance.com
IRDAI Regn. No.123 | PAN: AABCC6633K | CIN: U66030TN2001PLC047977 | **REACH US THROUGH WHATSAPP** 7305234433

Name of Treating Doctor		Name of Clinic / Hospital
Address		
Contact number	Nature of Disease/Injury (Please describe briefly)	
Hospital expenses (Please show each head separately; please mention in US Dollars)		
Room Rent	Consultancy Charges	Cost of Treatment
Other Costs	Outpatient Expenses	Total Claim Amount

4. Total Loss of Checked-In Baggage - Please attach the details of individual items lost, approximate cost and purchase date, Copies of baggage tags, Copies of correspondence with airline authorities / others about loss of checked baggage, along with details of compensation received from airlines / other authorities (if any), Property Irregularity Report (obtained from airline), Copy of the passport / visa with entry & exit stamp, Adequate proof of ownership of items contained within checked- in-baggage valued in excess of the Indian rupee equivalent of US $ 100 for loss/delay of checked-in-baggage will need to be submitted.

Number of Checked – In Baggage ______

Nature and description of the items lost ______

Description of the items lost with regards to number, nature and cost of each item ______

Total Claim Amount ______

5. Delay of Checked-In Baggage - Please attach the details of items purchased during the delay period, Copies of baggage tags, Copies of correspondence with airline authorities certifying the delay, along with details of compensation received from airlines / other authorities (if any), Property Irregularity Report (obtained from airline), Original bills / receipts / invoices connected to expenses incurred / purchases made during the delay period, Copy of the passport / visa with entry & exit stamp.

Name of Airline ______ Flight Number ______

From ______ To ______

Scheduled Departure Date and time ______ Scheduled Arrival Date and time ______

Actual Departure Date and time ______ Actual Arrival Date and time ______

Description of items purchased with regards to number, nature and cost of each item ______

6. Loss of Passport - Please attach Copy of new passport, Copy of previous passport (if available), Original bills / invoices of expenses incurred for obtaining a new passport, Copy of FIR / police report.

Date of Loss DDMMYYYY Application Document Fee ______

Incidental Cost ______ Total Claim Amount ______

7. Loss of International Driving License – Please attach Copy of new International Driving License, Copy of previous International Driving License (if available), Original bills / invoices of expenses incurred for obtaining a new International Driving License, Copy of FIR / police report.

Date of Loss ______ Application Document Fee ______

Incidental Cost ______ Total Claim Amount ______

8. Personal Accident - Overseas – Please attach Police report, Post Mortem Report, Death certificate, Medical report in the enclosed format, Certificate from treating Doctor for Permanent Disability.

Date and time of Accident ______ Full description of the cause of accident ______

Name of Treating Doctor ______ Name of Clinic / Hospital ______

Address ______

Contact number ______ Total claim amount ______

9. Personal Liability – Please attach the Judgment of the Court

Date and time of Accident DDMMYYYY Nature of Claim being made ______

Court where the case is being pursued ______

Total amount of the award including claimant amount ______ Total claim amount ______

10. Financial Emergency – Please attach the Police report

Date and time of Loss DDMMYYYY Place of Loss ______

Amount of the fund lost ______ Total claim amount ______

11. Hospital Daily Cash

Total number of days for amount being claimed from ______ Total claim amount ______

12. Hijack Relief - Please attach the copy of passport / visa with entry & exit stamp (if any), copy of the ticket and boarding pass, the police report with details such as the passport number of the Insured & period of hijacking, newspaper report (if available)

Name of Airline ______ Flight Number ______ From ______ To ______

Scheduled Departure Date and Time ______ Scheduled Arrival Date and Time ______

Date and time of Hijack ______ Date and Time of Return ______

Full description of the incident ______

13. Trip Cancellation - Please attach the details of expenses incurred, Original bills of expenses incurred due to cancellation, Copies of cancellation correspondence with airline authorities, hotel, car rental and tour operator certifying the cancellation, along with details of compensation received from airlines / other authorities (if any), Copy of ticket & boarding pass (if any), Copy of the passport / visa with entry & exit stamp (if any), Proof of the reason for cancellation like Death certificate etc.

Name of Airline ______ Flight Number ______ From ______ To ______

Scheduled Departure Date and Time ______ Reason for Trip Cancellation ______

Total Claim Amount ______

14. Trip Curtailment - Please attach the details of expenses incurred, Original bills of expenses incurred due to cancellation, Copies of cancellation correspondence with airline authorities, hotel, car rental and tour operator certifying the cancellation, along with details of compensation received from airlines / other authorities (if any), Copy of ticket & boarding pass (if any), Copy of the passport / visa with entry & exit stamp (if any), Proof of the reason for cancellation like Death certificate etc.

Name of airline ______ Flight Number ______ From ______ To ______

Scheduled Departure Date and Time ______ Reason for Trip Curtailment ______

Total Claim Amount ______

15. Trip Delay - Please attach the details of items purchased during the delay period, Original bills of purchases made / expenses incurred during the period of delay, Copies of correspondence with airline authorities certifying the delay, along with details of compensation received from airlines / other authorities (if any), Copy of ticket & boarding pass, Copy of the passport / visa with entry & exit stamp.

Name of Airline ______ Flight Number ______ From ______ To ______

Scheduled Departure Date and Time ______ Scheduled Arrival Date and Time ______

Actual Departure Date and Time ______ Actual Arrival Date and Time ______

Description of items purchased with regards to number, nature and cost of each item ______

Total Claim Amount ______

16. Emergency Travel Expenses - Replacement of Colleague Abroad - Please attach the details of expenses incurred, Copy of ticket & boarding pass (if any), Copy of the passport / visa with entry & exit stamp (if any), Proof of the reason for replacement like Name & Certificate Number of the Employee Hospitalised etc.

Name of Airline ______ Flight Number ______ From ______ To ______

Scheduled Departure Date and time ______

Letter from the Insured designating the Replacement Colleague stating the reason for Replacement ______

Total Claim Amount ______

17. Emergency Medical Expenses - Domestic (Accidental Hospitalization only within India from Residence to Airport and/ or vice versa) Please attach Doctor's reports, Original admission / discharge card, Original bills / receipts / with prescriptions and diagnostic /investigative reports, Copy of passport / visa with entry & exit stamp and copy of the ticket and boarding pass (as applicable).

Date and Time of Accident ____________________ Full description of the cause of accident ____________________

Date when treatment started ____________________ Date when treatment ended ____________________

Date of Admission ____________________ Date of Discharge ____________________

Name of Treating Doctor ____________________ Name of Clinic / Hospital ____________________

Address ____

Contact number ____________________ Nature of Injury ____________________

Hospital expenses (Please show each head separately)

Room rent ____________________ Consultancy Charges ____________________

Cost of treatment ____________________ Other costs ____________________

Outpatient expenses ____________________ Total Claim Amount ____________________

18. Personal Accident - Domestic – Please attach Police report, Post Mortem Report, Death certificate, Medical report in the enclosed format, Certificate from treating Doctor for Permanent Disability.

Date and time of Accident ____________________ Police report lodged - Yes/No

Full description of the cause of accident ____

Name of Treating Doctor ____________________ Name of Clinic / Hospital ____________________

Address ____

Contact Number ____________________ Total Claim Amount ____________________

PRIMARY INSURED / NOMINEE BANK ACCOUNT DETAILS	
a) Name of the primary insured	
b) Account number	
c) PAN number of the primary insured	
d) Bank name/ Branch	
e) Payee Name	
f) IFSC Code	
g) *Attach a cancelled cheque pertaining to the same name of the account holder must be printed on the cheque	
h) MICR No	
i) CKYC of the primary insured	

Note:
Enclose NEFT documents (Cancelled Cheque or Bank passbook clear copy)
Please send all original documents along with duly filled and signed Claim form to the address mentioned on the Top of the Claim form Please mention as “Health Claim Documents” on the TOP of the envelop and mention the complete sender address along with mobile number without fail.

Declaration by the Insured

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 TPA / 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 & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Place: Date: Signature of Claimant/Insured