JANASHAKTHI GENERAL INSURANCE LIMITED
Company No. PB 5179

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TRAVEL INSURANCE CLAIM FORM

Kindly note that the issue of this claim form cannot be taken as an admission of liability.

Policy No. [ ] Claim No. [ ]

1. GENERAL:

INSURED OR POLICY HOLDER

1. Full Name:..

2. Postal Address:.. ..
……………………………………………………………………………………………..

3. Telephone: Home ……………… Business ………………. Mobile …..............................
Fax No. ……………. Email Address ……………………………………….……

4. Business/Profession/Occupation:...

5. Passport Number:..

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2. HOSPITALIZATION & PERSONAL ACCIDENT CLIAMS :

i) DETAILS OF ACCIDENT IF ANY

a) Date : ….. Time : ....(am/pm)

b) State precisely where and how the accident occurred:
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………

ii) DETAILS OF THE INJURY

a) Name & Extent of injuries:
………………………………………………………………………………………………
………………………………………………………………………………………………

b) Name & Address of the medical Practitioner/Hospital who attend on the injured persons:
……
……

c) Have you ever previously suffered any injury of this nature?
……
……

iii) DETAILS OF ILLNESS IF ANY

a) Nature of Illness:
……
……

b) Date of Commencement of illness:..

c) Name & Address of the medical Practitioner/Consultant who treated, or is giving treatment for the illness:
……
……

d) Have the claimant previously suffered from similar illness: If yes, please give details:
……
……

iv) HOSPITALIZATION

a) Name of the Hospital:...

b) Period of Hospitalization: From:.............................. To: …..................................

c) Hospitalization charges incurred :.......................................
(Please attach bills and supporting documents including Doctors medical report in page 04 duly completed)

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3. OTHER CLAIMS

i) EVENT

a). State fully what happened:
……
……
……

b). Claim for the loss/delay

Description of purchases/property lost	Amount claimed (Rs.)

c). Date & Time of loss/delay:
……………………………………………………………………………………

d). Place where the loss/delay occurred:
………………………………………………………………………….

e). If there was a delay in your baggage, how long were you without it: ……… ….. hours/days

ii) LOSS/DELAY OCCURRED IN THE CUSTODY OF AN AIRLINE,

a). Date and Time reported to carrier: …..

b). Name of carrier:…...

c). Give the name and/or position of any person in authority to whom the matter was reported:
……………………………………………………………………………………………………
……………………………………………………………………………………………………

d). Did the carrier admit liability and if so amount paid for the loss/delay:
……………………………………………………………………………………………………

e). Give the details of alternate travel arrangements made by the Air line :
……………………………………………………………………………………………………

Documents Required:

* Air Line tickets
* Documents to prove the value of Lost baggage/Item/Article ((Eg: Bills/ Valuations /Sales literature etc)
* Originals of all written reports received from the carrier/letter of liability from the carrier
* Copies of all correspondents with Air Line
* If the claim is for delayed baggage, Please supply a letter from the carrier confirming reasons for the delay and duration of the delay including any bills for additional expenses
* In case of Burglary, a copy of the Police report for the lost items

Note :
Please attach documentary proof of all expenses incurred, including receipts, invoices, written responses received from the relevant authorities, travel itinerary etc.

I declare that all particulars contained in this form are true and complete to the best of my knowledge.

Signature : ……………………………….. Date : …………………………….

DOCTOR'S MEDICAL REPORT

1. Name of the patient :	
2. (a) For what injuries or illness was the treatment given by you ? (in block capitals)	(a)
(b) Are these consistent with the accident or Illness described in the previous pages ?	(b) Yes ☐ No ☐
3. (a) When in your opinion could the illness have been contracted or begun?	(a)
(b) When were you first consulted for the injury or illness ?	(b)
(c) Has he previously suffered from this injury or illness ? If 'Yes' when?	(c) Yes ☐ No ☐ Date: Day ☐ Month ☐ Year ☐
4. As a result of these injuries or illness how long has the patient been disabled from engaging in or attending to his usual employment or occupation ?	Totally from Day ☐ Month ☐ Year ☐ To Day ☐ Month ☐ Year ☐ Partially From Day ☐ Month ☐ Year ☐ To Day ☐ Month ☐ Year ☐
5. How much longer do you feel such disablement will continue?	Totally From Day ☐ Month ☐ Year ☐ To Day ☐ Month ☐ Year ☐ Partially From Day ☐ Month ☐ Year ☐ To Day ☐ Month ☐ Year ☐
6. Has the patient to your knowledge any other disease or physical defect? If 'Yes',	Yes ☐ No ☐
(a) What is the nature?	(a)
(b) To what extent may recovery be affected thereby?	(b)
7. What is your prognosis for a full and complete recovery?	

Signature : …………………………………………………. Qualifications: ……………………………………………………………..

Official Seal or Stamp

Name of the Doctor : ……………………………………………………………………………

Address : ………

AWT/CLM/2016-01

Day ☐ Month ☐ Year ☐