niva Bupa Health Insurance

Travel Claim Form

(To be filled in by the Insured Policyholder or Insured's Representative duly authorized by Power of Attorney. Issuance of this claim form is not to be taken as an admission of liability. Please attach all bills, receipts, credit card slips pertaining to your claim)

Policy/Certificate No. _____ Policy Period: From _____ To _____

1. A. Details of Policyholder

a. Name: _____
b. Address: _____
c. Phone No: _____
d. Email ID: _____
e. Relationship with policyholder: _____

B. Details of Claimant (If different than policyholder)

a. Name: _____
b. Address: _____
c. Phone No: _____
d. Email ID: _____
e. Relationship with policyholder: _____

2. Select the benefits for which claim is being made

	Emergency in-patient Medical Treatment		Escort of Minor Child		Flight Delay (Airlines)
	Emergency Outpatient treatment (OPD)		Adventure Sport		Mobility Aids Allowance
	Maternity		Sports Equipment Hire		Lifestyle Support (Modifications Made at Home/Vehicle)
	New Born Baby Cover		Rented sports equipment damage or loss		Missed Departure
	Road Ambulance Cover		Sports Equipment Cover		Terrorism cover
	Hospital Daily Cash		Sports Activity coverage		Loss of baggage and Personal Belongings
	Emergency Dental Treatment		Loan Protector		Loss of Identity documents
	Emergency Medical Evacuation		Legal Expenses		Key Replacement
	Extension to Inpatient Care		Upgradation to Business class		Change Fee Coverage
	Personal Accident		Study Interruption		Identity Theft
	Repatriation of Mortal remains		Sponsor Protection		Carrier Cancellation
	Total Loss of Checked-in Baggage		Cancer Screening & Mammographic Examination		Flight Diversion
	Delay of Checked-in Baggage		Bail Bond		Cruise cover
	Trip Delay		Refund of Visa fee		All Risk Cancellation
	Trip Cancellation		Home to Home		Trip Cancellation due to Domestic Disturbances and Inconvenience
	Trip Interruption		Political Risk and Catastrophe Evacuation		Covid Cover
	Loss of Passport		Colleague Replacement		Psychiatric Counselling
	Loss of International driving License		Loss of Laptop, Tablet, Mobile, Phone, Camera		Physiotherapy
	Missed Connection		Mugging Benefit		Kidnap distress allowance
	Financial Emergency Cash		Debit / Credit Card / FOREX CARD Fraud		Search and rescue expenses
	Personal Liability		Loss of Deposit on Cancellation (Hotel & Common Carrier)		Tele Medical Consultation
	Hijack Daily Allowance		Emergency Accommodation Coverage		Overseas Travel Service Supplier Insolvency
	Bounced Booking- Hotel/Common Carrier		Travel Loan Secure		Compassionate Visit

3. Hospitalization Related Claims: (Emergency in-patient Medical Treatment, Road Ambulance Cover, Hospital Daily Cash, Emergency Dental Treatment, Emergency Medical Evacuation, Extension to Inpatient Care, Adventure Sport, Covid Cover, *Terrorism cover, Home to Home, Maternity, New Born Baby Cover*)

a. Name/Nature of Sickness or Injury: _____
_____
b. Circumstances of Sickness/Injury: _____
_____
c. Ambulance details: _____

d. Please list the names and addresses of all treating physicians and hospitals:

Name	Address	Admission Date	Discharge Date	Contact Details

e. Attending Doctor's Report
i. Date of accident/sickness: _____
ii. Date of first treatment: _____
iii. Please describe in detail the nature of the Insured's injuries: _____
_____
iv. Was the hospitalization due to Pregnancy? Yes/ No (If Yes, please provide the details below)
Date of Delivery: _____ Gravida Status: _____
v. Was the accident due to any pre-existing condition? If yes, please give details_____
_____
vi. Can the patient be evacuated back to the Republic of India? Yes/ No
vii. Reason for Medical Evacuation: _____
viii. Was treatment taken after coming back to India (If yes, please provide travel date and details)?
_____
_____
ix. Was the sickness or injury related to COVID? _____
_____

f. Attending Physician Information
i. Name of Attending Physician: _____
ii. Address: _____
iii. Phone: _____

iv. Date: _____ Place: _____ Signature of Attending Physician

Details of Expenses

S.No	Details of expenses	Date	Amount

4. Out-patient Claim: (Emergency Out-Patient Treatment, Psychiatric Counselling, Physiotherapy, Cancer Screening & Mammographic Examination)

a. Nature of Ailment: _____
b. State Diagnosis and nature of treatment taken: _____
_____
c. Dates of treatment: From_____ To _____
d. Name, address & telephone number of consulting physician/ hospital where treatment was taken: _____
_____
e. Provide name of any prescription medicine you are presently taking: _____
_____
f. Attending Doctor's Report
i. Date of accident/sickness: _____
ii. Date of first treatment: _____
iii. Please describe in detail the nature of the Insured's injuries/ illness: _____
_____
g. Attending Doctor's Detail

i. Name of Attending Physician: _____
ii. Address: _____
iii. Phone: _____

iv. Date: _____ Place: _____ Signature of Attending Physician

Details of Expenses

S.No	Details of expenses	Date	Amount

5. Claims Related to Accident *(Personal Accident, Loan Protector, Travel Loan Secure, Terrorism Cover, Home to Home)*

a. Please state circumstances of accident i.e. how, when, where it took place: _____
_____
b. Nature of Injury: _____
c. State diagnosis and nature of treatment/ surgery under taken: _____
_____
d. Provide name, address & telephone number of Hospital/ Clinic: _____
_____
e. Details of Loan (If Applicable): _____
_____
f. Attending Doctor's Report
i. Date of accident/sickness: _____
ii. Date of first treatment: _____
iii. Please describe in detail the nature of the Insured's injuries/ illness: _____
_____
iv. Was the accident due to any pre-existing condition? If yes, please give details: _____
_____
v. Can the patient be evacuated back to the Republic of India? Yes / No
vi. Loss Incurred (Please Tick)
Death
Permanent Total Disability: Details _____
Permanent Partial Disability: Details _____
g. Attending Doctor's Detail
i. Name of Attending Physician: _____
ii. Address: _____
iii. Phone: _____

iv. Date: _____ Place: _____ Signature of Attending Physician

6. Hijack & Kidnap Related Claim *(Hijack Daily Allowance, Kidnap distress allowance)*

a. Details: _____
b. Place of Hijack/ Kidnap: _____
c. Place of Release: _____
d. Dates of Hijack/ Kidnap: From _____ To _____
e. Time of Hijack/ Kidnap: From _____ To _____

7. Repatriation of Mortal Remains Claim

a. Cause/Circumstances of death: _____
b. Date of death of Insured: _____

Details of expenses incurred for repatriation of Remains/ Funeral:

S.No	Details of expenses	Date	Amount

8. Loss/ Delay of Checked in Baggage

a. Describe when & where the Loss/ Delay took place: _____
_____
b. State the extent of Delay/ Loss: _____
_____
c. Name the common carrier: _____
d. Flight No: _____
e. Port of Delay/ Loss: _____
f. Actual Date & Time of Arrival of flight at Port: _____
g. Actual Date & Time when Bags were delivered: _____
h. No. of Hours of bag delay: _____
i. Had the common carrier been notified at the time of loss? Yes/ No
j. Details of compensation received from carrier: _____
k. Details of FIR, if filed: _____
l. Details of delayed/ lost item: _____
_____

9. Loss of Documents *(Loss of Passport, Loss of International driving License, Loss of Identity documents)*

a. Please provide details of the incident leading to loss: _____
_____
b. Date of loss: _____
c. Place of loss: _____
d. Details of lost items: _____
e. FIR No and copy attached? Yes/ No: _____
f. Expenses incurred related to Loss of Documents

S.No	Details of expenses	Date	Amount

10. Legal Claims *(Personal Liability, Legal Expenses, Bail Bond)*

a. Name and contact details of police authority: _____
b. Details : _____
_____
c. Date & Place: _____
d. Name of aggrieved Third Party: _____
e. Is this offense bailable as per the laws of the country? Yes/ No
f. If bail required, please attach the court order stipulating the required amount as bail bond. Please attach more sheets to give details
g. Amount of Liability: _____

11. Financial Emergency Cash Claim

a. Date of Loss: _____
b. Reason and circumstances of Loss: _____
_____
c. Items lost: _____
I hereby declare that the above reason was the sole reason for loss of my travel funds. I also declare that there are no other sources of funds available to me and the financial assistance required by me are needed on an urgent basis to prosecute the remainder of my trip. I have made all efforts to recover my money unsuccessfully

Signature of insured

12. Trip Cancellation/ Interruption Claim *(Trip Cancellation, Trip Interruption, Overseas Travel Service Supplier Insolvency, Trip Cancellation due to Domestic Disturbances and Inconvenience, All Risk Cancellation, Change Fee Coverage, Refund of Visa fee)*

a. Details of Carrier: _____
_____
b. Reason for claim: _____
_____
c. Date: _____
d. Original Travel Dates: From: _____ To: _____

S.No	Details of expenses	Amount

13. Flight/ Cruise Related Claims *(Missed Connection, Missed Departure, Cruise Cover, Flight Diversion, Carrier Cancellation, Flight Delay)*

a. Original Travel Schedule: (Please give date and time of all flights/ Cruise, mentioning the original and actual arrival and departure times. Please also mention the name of carriers and flight/ Cruise numbers): _____
_____
b. Reason for claim _____
_____
c. Date: _____ Time: _____

Details of expenses incurred:

S.No	Details of expenses	Amount

14. Trip Delay Claim

a. Reason for Trip Delay: _____
_____
b. Original Travel Schedule: (Please give date and time of all flights, mentioning the original and actual arrival and departure times. Please also mention the name of carriers and flight numbers): _____
_____

c. Date and Time of Trip Delay: _____
_____

d. No of hours by which trip got delayed: _____

15. Hotel/ common carrier Booking Related Claim *(Bounced Booking- Hotel/Common Carrier, Loss of Deposit on Cancellation (Hotel & Common Carrier), Emergency Accommodation Coverage)*

a. Reason for Bounced Booking: _____
_____

b. Original Travel/ Accommodation Dates: From _____ To _____
c. Cost of booking/ deposit: _____
d. Details of alternate booking: _____
e. Details of expenses incurred:

S.No	Details of expenses	Amount

16. Compassionate Visit Claim *(Compassionate Visit, Colleague Replacement, Escort of Minor Child)*

a. Members travelling with you on your trip: _____
_____

b. Name of the person hospitalized: _____
c. Provide name, address & telephone number of Hospital/ Clinic: _____
_____

d. Treating Doctor's details: _____
_____

e. Reason for hospitalization: _____
_____

f. Dates of hospitalisation: From _____ To _____
g. Attending Doctor's Report:
i. Date on which doctor was contacted: _____
ii. Nature & Details of Ailment: _____
_____

iii. State diagnosis and nature of treatment provided: _____
_____

iv. Was the ailment due to Pregnancy? Yes/ No
v. Was the ailment aggravated due to any pre-existing condition? If yes, please give details: _____
_____

S.No	Details of expenses	Amount

17. Loss of Laptop, Tablet, Mobile Phone, Camera claim *(Loss of Laptop, Tablet, Mobile Phone, Camera claim, Rented sports equipment damage or loss, Sports Equipment Cover, Loss of baggage and Personal Belongings, Mugging Benefit, Sports Equipment Hire)*

a. Date of Loss: _____
b. Reason and circumstances of Loss: _____
_____

c. Fir number (if applicable): _____
_____

Details of the items lost

S.No	Details of Items	Amount

I hereby declare that the above reason was the sole reason for the Loss. I have made all efforts to recover my lost items but was unsuccessful.

Signature of Insured

18. Sponsor Protection Claim

a. Name of the sponsor: _____
b. Date of demise of sponsor: _____
c. Cause of demise of sponsor: _____
d. Name, address and telephone number of hospital/ clinic where treatment was given to the sponsor: _____
_____
e. Name of treating doctor of the sponsor: _____
f. Details of medical/ surgical treatment given to sponsor: _____
_____

Please attach medical reports, doctor's statement giving the details of the sponsor and cause of death, and the death certificate of the sponsor. Medical statements from relations/ spouse will not be accepted. Please attach more sheets to give details, if necessary.

g. Tuition fees Claimed: _____

19. Study Interruption Claim

Due to hospitalisation of the insured

a. Name, address and telephone number of hospital/ clinic where treatment is being given: _____
_____
b. Name of treating doctor: _____
c. Details of ailment: _____
_____
d. Cause of the ailment: _____
_____
e. Was the ailment/ incident caused due to/ aggravated due to a pre-existing condition? Please give details: _____
_____
f. Date of onset of ailment: _____
g. Nature of treatment: _____
h. Dates of hospitalisation: From _____ To _____
i. Reason for medical evacuation (if applicable): _____
j. Reason for not continuing studies abroad: _____
k. Tuition fees paid in advance for the year: _____

Due to death of sponsor or immediate family member

a. Name of the sponsor/ immediate family member: _____

b. Cause of death: _____
c. Date of death: _____
d. Name, address and telephone number of hospital/ clinic where treatment was given to the sponsor/ the immediate family member: _____
_____
_____
e. Name of treating doctor: _____
f. Details of medical/ surgical treatment: _____
g. Tuition fees paid in advance for the year: _____

Please attach medical reports, statements from the treating doctor and death certificate as proof of the above. Medical statements from relations or spouse will not be accepted. Please also attach the receipts of the university fees paid. Please attach more sheets to give details, if necessary.

20. Up gradation to Business Class Claim

a. Name of the person hospitalized: _____
b. Provide name, address & telephone number of Hospital/ Clinic: _____
_____
c. Treating Doctor's details: _____
d. Dates of hospitalisation: From _____ To _____

Attending Doctor's Report
e. Date on which doctor was contacted: _____
f. Nature of Ailment: _____
_____
g. State diagnosis and nature of treatment provided: _____
_____
h. Was the hospitalization due to Pregnancy? Yes/ No
i. Was the ailment aggravated due to any pre-existing condition? If yes, please give details: _____
_____
j. Original booked flight details: _____
k. Business class Flight details: _____

21. Claim related to Fraud *(Identity Theft, Debit / Credit Card / FOREX CARD Fraud)*

a. Location of the incident: _____
b. Time of the incident: _____
c. Details of the incident: _____
_____
d. Has the incident been reported to the proper authorities: Yes/No
e. FIR No (If Applicable): _____
f. Details of expense related to Fraud:

S.No	Details of expenses	Amount

22. Claims not falling in above categories

a. Type of claim: _____
_____
b. Incidence of claim description: _____
_____
c. Place of loss: _____
d. Date of loss: _____

e. Claimed amount:

S.No	Details of expenses	Amount