OVERSEAS TRAVEL INSURANCE CLAIM FORM

IMPORTANT:

Claim should immediately be notified to the "Paramount Healthcare Management Pvt. Ltd." at the destination of occurrence. The contact details are as follows;

Description	Contact Numbers
Dedicated Helpline No.	+91 22 40908319
Regular Helpline No.	+91 22 40004219
Mobile and WhatsApp No.	+91 7718806681
US Toll Free No.	+1 866 978 5205

Email: travelhealth@paramount.healthcare

Please note, the policy deductible must be borne by the insured.

Certificate/Policy No. **Period from:** **to:**

Our Reference No. (Claim No.)

DETAILS OF PATIENT/INSURED PERSON

Name

Permanent Address (Sri Lanka)

.....

.....

.....

Email Id:.....

Date of Birth: ---------/----------/-------- Sex: M / F

Assistance Company Ref No:..... Passport No:.....

Date of Departure: ---------/----------/-------- Flight No..... From ..... to .....

Date of Arrival : ---------/----------/-------- Flight No..... From ..... to .....

Please indicate whether claim is in respect of: ☐ Accident & Sickness ☐ Travel Delay ☐ Baggage Loss
☐ Loss of Single Article ☐ Baggage Delay ☐ Loss of Passport

Please complete the Section relevant to your claim.

LOSS/DELAY OF CHECKED BAGGAGE

Describe when & where the loss/delay took place:.....

.....

State the extent of Loss:.....

.....

Name the common carrier:.....

1. Flight No..... From..... to.....
2. Flight No. ..... From..... to.....

Has the common carrier been notified at the time of loss? ☐ Yes ☐ No Airline reference No.....

Details of compensation received from the carrier :.....

Scheduled date/time of Arrival : ---------/----------/---------- hrs.

Actual date/time when bags delivered: ---------/----------/---------- hrs.

No. of hours delayed:.....

Item Purchased/Lost*	Date of Purchase	Place	Cost
		TOTAL	
Less compensation received from Airline:			
Net Amount			

In case of Delay, please provide details of purchases made
In case of Loss, please provide details of items lost.

LOSS OF PASSPORT/DRIVING LICENSE/NATIONAL IDENTITY CARD.

Please provide details of the incident i.e. when, where and how it happened :

.....
.....
.....
.....

Details of Police Report (please attach copy) No: Date: Place:

Details of Expenses incurred	**Date**	**Place**	**Amount**
		TOTAL	

TRAVEL DELAY

Flight No:..... Date: ---------/----------/-------- From..... To .....

Scheduled time of Departure..... Actual date of departure:..... No. of hours delayed:.....

Whether accommodation & boarding provided by carrier ☐ Yes ☐ No

Details of Expenses incurred	**Date**	**Place**	**Amount**
		TOTAL	

MEDICAL ACCIDENT & SICKNESS BENEFIT

If accident, details of accident i.e. how, when, where it took place:.....
.....
.....
.....
Date:..... Place :.....

If sickness, state nature and diagnosis and advise when and where symptoms first occurred:.....
.....
.....
Date: ..... Place: :.....

Name and address of consulting physician :.....
.....
.....
Have you ever been treated for this illness before: ☐ Yes ☐ No
If yes, provide name & address of consulted physician:.....
.....
.....
Provide name and address of your family physician:.....
.....
.....
Provide name of any prescription medicine you are presently taking:.....
.....
Indicate other health insurance coverages, including name, address, policy number & certificate number of insurer:
.....
.....
.....

DETAILS OF MEDICAL EXPENSES

Details of treatment	In/Out Patient		Charges(Currency)	Status of Payments
	From	To	Eg:USD/Euro	Paid/Outstanding
			Paid	
			Outstanding	
			TOTAL	

Whether Assistance Co. was contacted: ☐ Yes ☐ No. If Yes, Reference No. .....
If No, give reasons :.....
.....
.....
(Please see below for Doctors authorization page)

CONTINENTAL INSURANCE LANKA LIMITED
Company Reg No. PB 3784
No.79, Dr. C.W.W.Kannangara Mawatha, Colombo 7. Sri Lanka. Tel : 011 5 200 300 Fax : 011 5200 211 Web: www. cilanka.com

AUTHORIZATION

I hereby authorize any hospital, physician, or other person who has attended or examined me to furnish to the company, or its authorized representative, an and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records, a Photostat copy of this authorization shall be considered as effective and valid as the original.

Date: Place:

Signature of insured:_____

Attending Doctors Report

Patient's Name : Age: Sex: M/F

Address:

Date contacted: Time:

For Accidental Injury

Nature of Injury:

X-Ray Taken: ☐ Yes ☐ No Date taken:

Diagnosis and Treatment Given:

Describe any other disease or infirmity affecting present condition:

For Sickness

Nature of illness:

Diagnosis and Treatment Given :

When did patient's symptoms first appear:

Describe any other disease or infirmity affecting present condition:

Is condition due to pregnancy: ☐ Yes ☐ No Is illness due to any pres existing condition: ☐ Yes ☐ No

Signature: ……
Attending Doctor's Signature

Reimbursement claims Check List

Basic requirements

- ☐ Duly filled claim form
- ☐ Original invoices & receipts
- ☐ Copy of passport with entry/exit stamp
- ☐ Copy of travel itinerary

For Medical claims

- ☐ Doctor consultation papers/report
- ☐ Pathology reports, X-rays as applicable
- ☐ Copy of the admissions discharge card
- ☐ Doctor's prescription

For loss/Delay of checked baggage

- ☐ Copy of property Irregularity report(PIR)
- ☐ Copies of correspondence with Airline/Other authorities about loss of Checked baggage
- ☐ Details of Compensation received from Airlines/Other authorities if any
- ☐ Copies of Boarding pass and baggage tags
- ☐ Individual list of items in each baggage with approximate cost of each item

For Loss of Passport/DL/NIC

- ☐ Copy of FIR/ Police Report
- ☐ Original invoices & receipts
- ☐ Copy of passport with entry/exit stamp
- ☐ Copy of travel itinerary

For Travel Delay

- ☐ Correspondence with the Airline authorities certifying the reason for delay and date & time of actual departure.
- ☐ Copy of Boarding pass/Ticket
- ☐ Details of compensation received from Airlines