



**ACCIDENT AND SICKNESS CLAIM FOR TRAVEL COMPANION**

**INSTRUCTION**

1. This form is to be used when filling a claim for reimbursement of Medical Expenses.
2. Section A must be completed by the insured in full.
3. Following to be provided
  - a) Section B to be completed by the attending physician
  - b) Itemized bills with : claimant's name/nature of illness/injury, summary of treatment and charge for each service.
4. This form must be signed and dated in all applicable sections.
5. This form and all attached bills must be submitted to the Policy issuance office.

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 the conditions of the insurance contract.

Policy No:..... Plan: .....  
 Is International SOS Authorization obtained? Yes No If yes, SOS case No:.....

**SECTION A**

1. Name of Insured :.....  
 Date of Birth :..... Gender: Male Female
2. Name of Claimant :.....  
 Claimant's Date of Birth :..... Gender: Male Female
3. Current Residence Address and Tel. No :.....  
 .....
4. Date of Arrival in Country :..... Date schedule to return to Sri Lanka :.....
5. If Accident, provide details. i.e. how, when and where accident occurred :.....  
 .....
6. If sickness, advice what and when symptoms first occurred :.....  
 .....
7. Name and address of consulting physician (s) :.....  
 .....
8. Have you ever been treated for this illness before? Yes No  
 If yes, provide name and address of treating physician (s) and date (s) of first consultation  
 .....
9. Provide Name and Address of your family doctor/specialist :.....  
 .....
10. Please list name of medications you are presently taking :.....  
 .....
11. Please furnish details of any Health insurance policy you are holding :.....  
 .....

**Authorization**

1. the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agent group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the insurance company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provide to, person whose death. Injury, sickness or less is the basic of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payment under the Policy Number identified above. I authorize the group policyholder, employer or benefits plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the policy identified above and that a copy of this authorization shall be considered valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

.....  
Signature of claimant or Parent, if claimant is minor

.....  
Date

I hereby certify that the above information is true and correct to the best of my knowledge and belief

.....  
Signature

.....  
Date

**SECTION B**  
**Attending Physician's Statement**

To be completed by the Doctor/s consulted while traveling overseas.  
Policy No (Specify the digits)

1. Name of injured person
2. Age
3. Occupation
4. Address
5. Please state nature of the disease/accident in detail
6. Does the cause of disease/accident as stated by the claimant  
Tally with your examination findings
7. Are the injuries solely due to the accident or traceable to any  
Previous injuries/disease?
8. Was the injured person suffering form any disease or injury,  
Which may have contributed to the accident or likely to  
Aggravate his condition?
9. Please mention past history of any diseases, accident or  
Hospitalization with details
10. Was the claimant hospitalization during the current event?  
If so far what period?
11. Please give detail of the treatment given and operation/surgical  
Process performed
12. List all dates of treatment : from ..... to.....  
Out patient clinic  
Hospitalization
13. Was the patient under influence of intoxicant or drugs?
14. Are you his usual medical attendant? If you have treated him for  
any previous illness or injury. Please give details.  
How long do the record that you hold go back?
15. As other doctors been in attendance or consulted? If yes, please  
give details. When was the medical advice last sought and why?
16. Has this accident been reported to Policy? If yes, please mention  
The Case No. and Police advise last sought and why?
17. Is this claimant in your option totally disabled from each and  
Every occupation? How long the claimant is away from his/her  
Duty?
18. What is the Prognosis?
19. Doctor's Name, Address and Telephone no:

Doctor's Signature

Date of Visit : .....