POLICY EXTENSION / RENEWAL REQUEST FORM

I, we hereby furnish the below records for application of the current / running Travel Guard / DTG policies issued by TATA AIG as below.

Name of the Applicant / Insured: ____

Applicant / Insured Email Id: ____

Where is/are the insured currently? ___ Present Location of Insured_________________________________

Departure Date from INDIA: DD/MM/YYYY (Trip Start Date) [Please share Proof of Travel]

Extension Required: From DD/MM/YYYY to DD/MM/YYYY

Why extension is required? ___ Please share the reason for extension _______________________________

Any previous extensions done: ___Yes / No - Please share the prior policy numbers_____________________

Policy Number	Insured Name	Please specify Pre-existing medical condition (prior to departure from India).	Does the insured has / have claims during the current overseas trip	Type of claim / Diagnosis*	Approx. Claim amount / cost	Claim Number if registered
			Yes / No			
			Yes / No			
			Yes / No			

*Medical documents should contain the information related to the treatment taken, diagnosis report, discharge summary, OPD or IPD papers / reports, consultation papers or any other documents which may be necessary for evaluation of the claims. Please share complete set of medical documents along with the extension form for evaluation of the extension request

Any extension if accepted by Us is subject to medical condition, claim history and reoccurrence nature of medical condition which could result in a claim during the extension period.

#Additional information (if any) ____

Declaration:

I hereby confirm that I am an Indian Resident and I am not travelling on an Immigrant Visa.

I hereby confirm Initial (fresh/ new) policy was purchased whilst the insured was in India and the trip has started from India.

I confirm I am currently in good health and declare that there has **been a change** / **no change** in my Personal physical & medical condition since the date of inception of the first policy.

I understand that any incorrect information about claim or personal/ physical/medical condition shall invalidate this extension. The company will also not be liable to pay any claim filed under the extended Policy and No refund of premium will be processed.

* Date: DD/MM/YYYY

* Place: ______________

Signature of Insured / Applicant (Relationship with Insured)