ApolloMunich HEALTH INSURANCE

TOLL FREE 1800-102-0333 • www.apollomunichinsurance.com • E-mail : customerservice@apollomunichinsurance.com

Apollo Munich Health Insurance Co. Ltd.
10th Floor, Tower-B, Building No. 10,
DLF Cyber City, DLF City Phase -II, Gurgaon, Haryana-122002

CLAIM FORM

Issuance of this form does not amount to admission of any liability or a waiver of any of the terms and conditions of the insurance contract. If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or any Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy shall be void and all benefits paid under it shall be forfeited.

Please give the following information correctly and completely to enable us to process Your claim promptly. Use additional sheets, if required. We may call for additional document/information as relevant.

A) Details of the Policy

Policy Number (in full)____________________
Certificate Number (for Group Policies)____________________
Policy Commencement Date (DDMMYYYY)____________ Policy Expiry Date (DDMMYYYY)____________
Name of Policyholder____________________
Claim Reference provided during intimation____________________

B) Details of the Insured Person

Name of the Insured Person ____________________
Date of Birth (DDMMYYYY)____________________ Gender: Male☐ /Female☐
Passport Number____________________
Permanent Address in India____________________

Residence Address abroad____________________

Occupation____________________
Relationship to the Policyholder & other Insured Person____________________
Telephone (in India)____________ Mobile (in India)____________
Telephone (abroad)____________ Mobile (abroad)____________
Email-ID____________________

C) Details of the Claimant (if different than the Insured Person)

Name____________________
Date of Birth (DDMMYYYY)____________________ Gender: Male☐ / Female ☐
Passport Number____________________
Permanent Address____________________

Relationship to the Policyholder/Insured Person____________________
Telephone (in India)____________ Mobile (in India)____________
Email-ID ____________________

D) Details of the Claim

Please tick the applicable benefit You want to claim for

☐ Medical Treatment	☐ Dental Treatment	☐ Medical Evacuation	☐ Repatriation of Mortal Remains
☐ Loss or Delay of Baggage	☐ Loss of Passport	☐ Financial Emergency Cash	☐ Personal Accident & Common carrier
☐ Personal Liability	☐ Hijack Daily Allowance	☐ Substitute Employee	☐ Emergency Travel and Hotel
☐ Trip Cancellation	☐ Trip Delay	☐ Trip Curtailment	☐ Missed Connection
☐ Hospital Daily Allowance			

E) Medical Treatment/Dental Treatment/Hospital Daily Allowance

Please attach Doctor's reports, Original Admission/Discharge Card, Original Bills/Receipts/with Prescriptions and diagnostic/Investigative Reports, Copy of passport/visa with entry and exit stamp and copy of the ticket and boarding pass.

Name, Address and Contact Number of Treating Doctor/Physician/Dentist/Clinic or Hospital:

Downloaded from www.vibhutiinsurance.com - Broker : Vibhuti Insurance Brokers Pvt Ltd.

Name of the Disease contracted____________________
When Disease first manifested (Date)____________________
Dates of treatment: Start____________________ End____________________
Date of admission____________________ Date of discharge____________________
Nature of Disease/Injury (Please describe briefly)____________________

If Accident, please provide details, i.e. how, when and where it took place.

Please enclose Police Report, if available.

Please provide the cost details for the Expenses (Bills, Invoices, Prescriptions etc) in Section M of this claim form and mention the currency.

Please tick ☐ when You also claim for Hospital Daily Allowance.

F) Medical Evacuation/Repatriation of Mortal Remains

Please attach Doctor's reports, Original Admission/Discharge Card, Original Bills/Receipts/with Prescriptions and diagnostic/Investigative Reports, Copy of passport/visa with entry and exit stamp and copy of the ticket and boarding pass.

Name, Address and Contact Number of Treating Doctor/Physician/Dentist/Clinic or Hospital:

Name of the Disease contracted____________________
When Disease first manifested (Date)____________________
Dates of treatment: Start____________________ End____________________
Date of admission____________________ Date of discharge____________________
Nature of Disease/Injury (Please describe briefly)____________________

Reason for Medical Evacuation____________________

Date of Death (DDMMYYYY)____________________
Cause of Death____________________

Please attach the official Death Certificate and a Physician's statement for cause of death.

If Accident, please provide details, i.e. how, when and where it took place.

Please enclose Police Report, if available.

Please provide the cost details for the Expenses (Bills, Invoices, Prescriptions etc) in Section M of this claim form and mention the currency. Also, please provide, if applicable, name of the airline, burial details with bifurcation of incurred Expenses.

Downloaded from www.vibhutiinsurance.com - Broker : Vibhuti Insurance Brokers Pvt Ltd.

G) Loss or Delay of Checked-in Baggage

Please attach the original invoice/receipts with the details of individual items purchased during the delay period/individual items lost, cost and purchase date, copies of baggage tags, copies of correspondence with Airline Authorities/others about loss / delay of checked baggage, along with details of compensation received from Airlines/other authorities (if any), Property Irregularity Report (obtained from Airline), Copy of the passport/visa with entry and exit stamp, Adequate proof of ownership of items contained within checked-in-baggage valued in excess of the Indian rupee equivalent of US $ 100 for loss of checked-in-baggage will need to be submitted.

Name of the Carrier____________________

Flight Number__________ From____________________ To____________________

Scheduled Departure Date and Time____________________

Scheduled Arrival Date and Time____________________

Actual Departure Date and Time____________________

Actual Arrival Date and Time____________________

Date and Location of loss____________________

Date and time of Checked – In Baggage retrieval____________________

Number of Checked – In Baggage____________________

Description of the items lost with regards to number, nature and cost of each item____________________

____

____

Description of items purchased with regards to number, nature and cost of each item____________________

____

____

Total Claim Amount____________________

H) Loss of Passport/Financial Emergency Cash

Please attach copy of new Passport, copy of previous Passport (if available), Original Bills/Invoices of expenses incurred for obtaining a new passport, copy of FIR/Police Report.

Date and time of Loss____________________ Place of Loss____________________

Description of the circumstances of Loss____________________

____

____

Application Document Fee____________________

Incidental Cost____________________

Amount of the fund lost____________________

Total Claim Amount____________________

I) Personal Liability/Personal Accident and Common Carrier

Please attach Police Report, Post Mortem Report (in case of death), official Death Certificate (incase of death), Medical Report in the enclosed format, Certificate from Treating Doctor for Permanent Disability, Original photograph of the injured reflecting disablement, Judgment of the Court for Personal Liability.

Date and time of Accident____________________

Place of Accident____________________

Full description of the cause of accident____________________

____

____

____

Name, Address and Contact Number of Treating Doctor/Physician/Dentist/Clinic or Hospital:

____

____

____

Nature of Claim being made____________________

____

Court where the case is being pursued____________________

____

____

Downloaded from www.vibhutiinsurance.com - Broker : Vibhuti Insurance Brokers Pvt Ltd.

J) Hijack Daily Allowance

Please attach Police Report with details such as passport number and period of hijacking, copy of the Passport/visa with entry and exit stamp, newspaper reports/TV Clip or any other media coverage (if available).

Name of the Carrier ______________________
Flight Number______________ From______________ To______________
Scheduled Departure Date and Time______________________
Scheduled Arrival Date and Time______________________
Date and Time of Hijack______________________
Actual Date and Time of return______________________
Description of the incident______________________

____

____

____

K) Trip Delay/Trip Cancellation and Curtailment/Missed Connection

Please attach any detailed report/confirmation from the carrier/Hospital/Police/others of incident which leads to the delay /cancellation/curtailment of the flight/trip, copies of correspondence with Airline Authorities/others about delay/cancellation/curtailment, along with details of compensation received from Airlines/other authorities (if any), Original Admission/Discharge Card, Diagnostic /Investigative Reports of hospitalisation, official Death Certificate, copy of the Passport/visa with entry and exit stamp.

Name of the Carrier______________________
Flight Number______________ From______________ To______________
Scheduled Departure Date and Time______________________
Scheduled Arrival Date and Time______________________
Name of the Carrier______________________
Flight Number______________ From______________ To______________
Actual Departure Date and Time______________________
Actual Arrival Date and Time______________________
Description of incident______________________

____

____

____

Please provide the cost details for the Expenses (Bills, Invoices, Prescriptions etc) in Section M) of this claim form and mention the currency.

L) Substitute Employee/Emergency Travel and Hotel

Please attach Doctor's Reports, Original Admission/Discharge Card, Diagnostic/Investigative reports, (copy of Passport/visa with entry and exit stamp and copy of the ticket and boarding pass for the Insured Person as well as Substitute employee), certificate from the employer establishing the official visit of both employees.

Name, Address and Contact Number of Treating Doctor/Physician/Dentist/Clinic or Hospital:

____

____

____

Date of admission______________________ Date of discharge______________________
Nature of Disease/Injury (Please describe briefly)______________________

____

____

____

Relationship to the other Insured Person______________________

Please provide the cost details for the Expenses (Bills, Invoices etc) in Section M of this claim form and mention the currency.

Downloaded from www.vibhutiinsurance.com - Broker : Vibhuti Insurance Brokers Pvt Ltd.

M) Details of Expenses

No.	Expense Details	Issued by	Currency	Amount	Amount of received reimbursement	Remarks

N) Declaration

I, the undersigned, authorise any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organisation, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to Apollo Munich Health or its representatives, any and allinformation with respect to any injury or illness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, illness or loss is the basis of claim and copies of all that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I understand that this authorisation is valid for the term of coverage of the Policy identified above and that a copy of this authorisation shall be considered as valid as the original. I understand that I or my authorised representative may request a copy of this authorisation.

I hereby declare and warrant that:

(1) I have read and understood the terms, conditions and exclusions of this Policy, and
(2) that the foregoing particulars are true and complete in all material respects, and
(3) there is no other insurance in force that may apply to this claim.

Date and Place____

Signature____

Downloaded from www.vibhutiinsurance.com - Broker : Vibhuti Insurance Brokers Pvt Ltd.

ApolloMunich HEALTH INSURANCE

Apollo Munich Health Insurance Co. Ltd.
Off. 10th Floor, Tower-B, Building No. 10
DLF Cyber City, DLF City Phase -II, Gurgaon, Haryana-122002

O) Medical Report (to be filled by Treating Doctor)

Patient's Name____________________

Date of Birth (DDMMYYYY)____________________ Gender: Male ☐ / Female ☐

Patient's Address____________________

____

____

Date and Time of first consultation____________________

Dates of treatment: Start____________________ End____________________

Date of admission____________________ Date of discharge____________________

Nature of complaints____________________

____

____

Diagnosis____________________

Treatment given____________________

____

____

History of presented complaints____________________

____

____

____

Is the present condition due to pregnancy? Yes ☐ No ☐ If yes, provide details____________________

____

____

Is the present condition due to any pre-existing condition? Yes ☐ No ☐ If yes, provide details____________________

____

____

Please provide history of any disease, accident or hospitalisation with details and duration____________________

____

____

Date and Time of the accident____________________

Are the injuries suffered solely due to the accident? Yes ☐ No ☐ If no, provide details____________________

____

____

Was the patient under influence of alcohol/drugs at the time of the accident? Yes ☐ No ☐

Is the injured person totally disabled from each and every occupation? Yes ☐ No ☐

Is the injured person partially disabled from occupation? Yes ☐ No ☐ If yes, please provide the percentage of disability

____

Prognosis of the ailment/injury____________________

____

In your opinion when will the injured person be able to resume duties?____________________

I hereby to the best of my knowledge and belief, warrant the truth of the above details in every respect.

Place____________________ Date____________________ Reg.No.____________________

Name, address and stamp of Doctor____________________

____

____

Signature____________________

Downloaded from www.vibhutiinsurance.com - Broker : Vibhuti Insurance Brokers Pvt Ltd.