Insure Health
the simplest way to buy health insurance

ApolloMunich HEALTH INSURANCE

# 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

1. Policy Number (in full):_____

2. Apollo Munich Health Card No.:_____

3. Name of the Policyholder (in whose name policy is issued):_____

4. Details of the Insured Person (in respect of whose claim is made):

   i Name of the Insured Person:_____

   ii Relationship with the Policyholder : _____

   iii Date of Birth /Age: _____

   iv Occupation: _____

   v Current Residential Address & Contact Details (Telephone/Mobile No./E-Mail): _____

   _____

   _____

   _____

5. Nature of disease/illness contracted or injury sustained:_____

6. Date on which injury was sustained/Disease or illness first detected:_____

7. Details of the doctor:

   i Name and address of the attending medical practitioner:_____

   ii Qualification & telephone No.:_____

8. Details of the hospital:

   i Inpatient Bill No.:_____

   ii Name & Address of the Hospital/Nursing Home/Clinic where treatment is taken/being taken:

   _____

   _____

   iii Date | D | D | M | M | Y | Y | Y | Y | and time | H | H | M | M | of Admission in the hospital.

   iv Date | D | D | M | M | Y | Y | Y | Y | and time | H | H | M | M | of Discharge of the hospital.

9. Please tick as (√) specifying nature of claim as follows along with the Expense Details

| **Details of expenses** | **Amount** |
|---|---|
| ☐ 1. In-patient Treatment | Rs. _____ |
| a) General Hospitalization | Rs. _____ |
| b) Organ Donation /Transplantation | Rs. _____ |
| ☐ 2. Pre Hospitalization | Rs. _____ |
| ☐ 3. Post Hospitalization | Rs. _____ |
| ☐ 4. Day care Expenses | Rs. _____ |
| ☐ 5. Ayush Benefit | Rs. _____ |
| ☐ 6. Other expenses not included above | Rs. _____ |
| **Grand total** | **Rs.** _____ |

10. No. of Documents submitted including this CLAIM FORM: _____

11. Are you at present covered under any other similar type of insurance (Individual or Group Health Insurance, etc.)? [Y / N ]

If yes, please give particulars of each (name of insurance company, policy number, begin of coverage, sum insured).

_____

_____

**Declaration**

I hereby declare and warrant that:

(1) I have read and understood the policy terms, conditions and exclusions, 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.

I also authorise the TPA and Apollo Munich Health Insurance Company Limited to make payment of any claim or part of a claim found to be admissible as per the terms, conditions and limitations of the policy to the hospital on my behalf as full and final settlement of any liability under the Policy. I will keep indemnified and hold Apollo Munich Health Insurance Company Ltd., harmless from any claim under this Policy by any third party, including any hospital or other place from which treatment has been taken or services obtained.

Place and Date: _____

Signature of the Claimant / Insured Person:_____

**Check List of Enclosures for Submission of Claim**

**In-patient Treatment /Day Care Procedures**

- ☐ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.
- ☐ Original Detailed Discharge Summary / Day care summary from the hospital.
- ☐ Original consolidated hospital bill with break up of each Item, duly signed by the Insured Person.
- ☐ Original payment receipt of the hospital bill.
- ☐ First Consultation letter and subsequent Prescriptions.
- ☐ Original Bills, original payment receipts and reports for Investigation.
- ☐ Original Medicine bills and receipts with corresponding Prescriptions.
- ☐ Original invoice/bills for Implants (viz. Stent /PHS Mesh / IOL etc.) with original payment receipts.

**Organ Donation/Transplantation**

In addition to the documents of general hospitalization

- ☐ Organ Function test / blood test proving organ failure
- ☐ Treatment Certificate issued by the Transplant Surgeon of the hospital concerned.

**Road Traffic Accident**

In addition to the In-patient Treatment documents:

- ☐ Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.

**In Non Medico legal cases**

- ☐ Treating doctor's certificate giving details of injuries (How, when and where injury sustained)

**In Accidental Death cases**

- ☐ Copy of Post Mortem Report & Death certificate

**For Death Cases**

In addition to the In-patient Treatment documents:

- ☐ Original Death Summary from the hospital.
- ☐ Copy of the Death certificate from treating doctor or the hospital authority.
- ☐ Copy of the Legal heir certificate, if the claim is for the death of the principle insured.