GMC CLAIM FORM

PART I – Insured's Information

Name of Policyholder:
Policy No. _____ Certificate No. _____ (If applicable)

PART II – Claimant Information

Name of Patient:	
Occupation :	Date of Birth: Present completed age: ___
Address and phone number : _____	
Relationship to the Policyholder: ☐ Member / Employee (Spouse (Dependent Child (Dependent Mother (Dependent Father	
(1) Nature of sickness /disease/injury claimed for : _____ Date on which Injury was sustained or disease or illness first detected : _____ Date of first consultation : _____ Name, Address, Telephone No. of Doctor Consulted : _____ Qualification of the Doctor Consulted :_____	
(2) Have you had any prior treatment for this or related conditions? NO ( ) YES ( ) Doctor's Name : Qualification : Address & Telephone: Date(s)	
(3) Are you making any other insurance claim as a result of this hospitalization/surgery? NO ( ) YES ( ) Name of Insurance Company : Policy No. :	
(4) Was the hospitalization/surgery a result of an accident? NO ( ) YES ( ) (5) Place of Accident _____ Date of Accident _____	
(6) Details of hospitalisation	

Name of Hospital / Nursing Home	Address	Date of Admission	Date of Discharge

(7) CLAIM QUANTUM

Date	Nature of expenses incurred	Billed By	Amount (Rs)
		Total	

(If space is insufficient, please attach separate list)

In support of the above claim, I enclose the following original documents (Please tick)

☐ Hospital Discharge Card
☐ Bills, Cash Memos, Receipt from Hospitals
☐ Cash Memos, Receipts from Pharmacists, Pathology and Investigation Centres
☐ Bills, Cash Memos, Receipts from Attending Doctors, Surgeons, Anesthetists
☐ Doctor's prescriptions for medicines, pathological tests, hospitalisation, surgery, physiotherapy
☐ Any other documents. Please specify

_____

I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and I/We agree that if I/We have made, or in any further declaration the Company may require in respect of the said claim, shall make any false or fraudulent statement, or any suppression or concealment the Policy shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited

AUTHORISATION

I HEREBY AUTHORISE on behalf of the patient: (1) Any employer, medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organisation, institution or person, that has any records or knowledge of the patient and/or who has attended or may hereafter attend the patient to disclose such information to HDFC ERGO General Insurance Company; (2) HDFC ERGO General Insurance Company or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of the patient in relation to this claim. This authorisation shall bind the patient's successors and remains valid notwithstanding death or incapacity. A photocopy or facsimile copy of this authorisation shall be as valid as the original.

Date: Signature of Patient
Place:

This is to certify that the above-mentioned claim lodged by the Insured / Claimant is genuine and the same is recommended for reimbursement.

Authorised Signatory **Place:**

Name of Attending Physician: _____ **Phone No.** _____
Address: _____

I certify that the above named patient _____, was seen by me on _____ and has been fully cured of the sickness/injury claimed for, which first incurred on _____

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Attending Physician) _____

DATE ____/____/____

Name of the Policyholder & Seal: **Date:**

ATTENDING PHYSICIAN INFORMATION