ApolloMunich HEALTH INSURANCE

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 Policy. 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 the 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. We may call for additional document/information as required. Use additional sheet, if required.

A. Details of the Policy / Insured Person

Policy Number (in full): _____ Certificate Number: _____

Policy Period: Policy Commencement Date [DDMMYYYY] _____ Policy Expiry Date [DDMMYYYY] _____

Name of Policyholder: _____ Name of the Insured Person: _____

Date of Birth (DD/MM/YYYY): _____ Gender: Male ☐ Female ☐ Occupation: _____

Permanent Address in India: _____

Address Proof: Passport copy ☐ Electricity bill ☐ Telephone bill ☐ Driving license ☐ If Other, please specify _____

Telephone No.: _____ Mobile No.: _____ E-Mail: _____

B. Details of the Claimant (if different than the Insured Person)

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

Permanent Address: _____

Relationship to the Policyholder / Insured Person: _____

Telephone (in India): _____ Mobile (in India): _____ E-mail: _____

C. Details of the Claim

Please tick the applicable benefit You want to claim for:

☐ Personal Accident	☐ Medical Evacuation	☐ Transportation of Mortal Remains
☐ Personal Accident - Carrier	☐ Delay of Checked-in Baggage	☐ Trip Curtailment
☐ Medical Treatment	☐ Emergency Travel	☐ Personal Liability
☐ Total Loss of Checked-in Baggage	☐ Trip Delay	☐ Trip Cancellation
☐ Flight delay	☐ Emergency Hotel	

D. Medical Treatment

Please attach Medical Practitioner's reports, Original admission / discharge card, Original bills / receipts with prescriptions and diagnostic /investigative reports and Copy of the ticket, boarding pass & address proof.

In case of an accident, please provide details, i.e. how, when and where it took place:

_____

_____

_____

Dates of treatment: Start: _____ End: _____ Date of admission: _____ Date of discharge: _____

Nature of Disease /Nature of Injury (Please describe briefly) : _____

_____

_____

Name, Address and Contact Number of Treating Medical Practitioner/Physician/Dentist/Clinic or Hospital: _____

_____

_____

Please enclose Police Report, if available.

Sr. No.	Expense Details	Issued by	Amount (Rs.)	Amount of received compensation (Rs.)	Remarks
			Total		

E. Medical Evacuation / Transportation of Mortal Remains

Please attach Medical Practitioner's reports, Original admission / discharge card, Original bills / receipts with prescriptions and diagnostic /investigative reports and Copy of the ticket, boarding pass & address proof.

Name, Address and Contact Number of Treating Medical Practitioner /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 Evacuation: _____

_____

Date of Death (DDMMYYYY): _____ Cause of Death: _____

_____

Please attach the official death certificate and a physician's statement for cause of death.

In case of an accident, please provide details, i.e. how, when and where it took place.

_____

_____

Please enclose Police Report, if available.

Also, please provide (if applicable) – Name of Carrier, burial details with bifurcation of incurred Expenses.

Sr. No.	Expense Details	Issued by	Amount (Rs.)	Amount of received compensation (Rs.)	Remarks
		Total			

F. 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 Carrier authorities / others about loss / delay of checked baggage, along with details of compensation received from Carrier / other authorities (if any), Property Irregularity Report (obtained from Carrier), Adequate proof of ownership of items contained within checked-in-baggage valued in excess of Rs. 2000 & address proof.

Name of the Carrier: _____ Carrier 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: _____

Expense / Loss Details	Date	Place	Amount (Rs.)
Amount refunded by Carrier			
		Total	

G. Personal Liability / Personal Accident

Please attach Police report, Post Mortem Report (incase of death), official death certificate (in case of death), Medical report in the enclosed format, Certificate from treating Medical Practitioner for Permanent Disability, Original photograph of the injured reflecting disablement, Succession Certificate (in case of death of insured), Judgment of the Court for Personal Liability & address proof.

Date and time of Accident: _____ Place of Accident: _____

Full description of the cause of Accident: _____

_____

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

_____

_____

Nature of Claim being made: _____ Court where the case is being pursued: _____

* For Personal Accident, we shall provide a separate claim form up on notification

H. Flight Delay /Trip Delay/ Trip Cancellation and Curtailment

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 Carrier authorities / others about delay / cancellation / curtailment, along with details of compensation received from Carrier / other authorities (if any), original admission / discharge card, diagnostic / investigative reports of hospitalisation, official death certificate, invoices & receipts, Proof of Loss & address proof.

Name of the Carrier: _____ Carrier Number: _____ From: _____ To: _____

Scheduled Departure Date and Time: _____ Scheduled Arrival Date and Time: _____

Name of the Carrier: _____ Carrier Number: _____ From: _____ To: _____

Actual Departure Date and Time: _____ Actual Arrival Date and Time: _____

Cause of Incident (Flight Delay/Trip Delay/Trip Cancellation and Interruption):

_____

Description of incident: _____

Expense / Loss Details	Date	Place	Amount (Rs.)
Amount refunded by Carrier			
		Total	

I. Emergency Travel and Emergency Hotel

Please attach Medical Practitioner's reports, Original admission / discharge card, diagnostic / investigative reports, and copy of the ticket and boarding pass, invoices / receipts & address proof.

Address and Contact Number of Treating Medical Practitioner/Physician/Dentist/Clinic or Hospital:

_____

_____

Date of admission: _____ Date of discharge: _____

Nature of injury (Please describe briefly): _____

_____

Relationship to the Insured Person: _____

Expense Details	Date	Place	Amount (Rs.)
Amount refunded by Carrier & hotel			
		Total	

J. Direct payment in your bank account (optional)

Please provide the following details of your bank account and attach a cancelled cheque pertaining to the same account.

Bank Name: _____ Bank Branch: _____

Bank Account Number: _____ IFSC Code: _____ MICR No. : _____

Note: It is agreed that the Policyholder/ Claimant will intimate in writing to Apollo Munich Health Insurance Co. Ltd. about any change in bank account details.

Declaration

I, the undersigned, authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to Apollo Munich Health Insurance Company Limited or its representatives, any and all information 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 of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, including to determine eligibility for benefit payments under the Policy Number identified above. 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 as valid as the original. I understand that I or my authorized representative may request a copy of this authorization

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.

Signature: _____ Date and Place: _____

Customer Identification Procedure (as per KYC norms of IRDA)	
Please submit the following documents in case of claim amount exceeds Rs. 100,000	
Legal name and any other names used (Any one of the mentioned documents)	Passport/ PAN Card/ Voter's Identity Card/ Driving License/ Letter from a recognized public authority or public servant verifying the identity and residence of the customer
Proof of Residence (Any one of the mentioned documents)	Telephone bill/ Bank account statement/ Letter from any recognized public authority/ Electricity bill/ Ration card

K. Medical Report (to be filled by treating Medical Practitioner)

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 Medical Practitioner: _____

_____

_____

Signature: _____