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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:

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.

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_____

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.

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_____

ApolloMunich HEALTH INSURANCE

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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_____