

**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.

**SECTION I: To be completed by the Policyholder / Insured Person or his representative**

**1. Details of the Policyholder**

Policy Number (in full): \_\_\_\_\_

Employee Number (for Group Policies): \_\_\_\_\_

Name of Policyholder: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date of Birth (DD/MM/YYYY): \_\_\_\_\_ Occupation: \_\_\_\_\_

TelephoneNo.: \_\_\_\_\_ MobileNo.: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**2. Details of Insured Person in respect of whom the claim is made**

Name of Insured Person: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date of Birth (DD/MM/YYYY): \_\_\_\_\_ Occupation: \_\_\_\_\_

TelephoneNo.: \_\_\_\_\_ MobileNo.: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Relationship with the Policyholder: \_\_\_\_\_

Date (DD/MM/YYYY) & time of injury/death: \_\_\_\_\_

Place/Address of accident/ death: \_\_\_\_\_

Details of the accident and nature of accident (Continue on a separate sheet if necessary): \_\_\_\_\_

\_\_\_\_\_

Did the accident happen when you were working?  Yes  No

If yes: Name & address of Employer: \_\_\_\_\_

Whether reported to Police:  Yes  No

If yes: Name and address of Police Station: \_\_\_\_\_

If not, please give reasons: \_\_\_\_\_

First Information Report (FIR) Number and Date: \_\_\_\_\_

Contact details of Police Station: \_\_\_\_\_

**3. Was the Insured Person moved to hospital immediately after the accident?**

Yes  No (If yes, please complete the following)

Name & address of the Hospital: \_\_\_\_\_

Date of Admission (DD/MM/YYYY): \_\_\_\_\_ Date of Discharge (DD/MM/YYYY): \_\_\_\_\_

**4. Witnesses**

Were there any witnesses to the event?  Yes  No (If yes, please complete the following)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_ Place of witness: \_\_\_\_\_

Phone No. (Home): \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_

Please attach all original witness statements if already obtained. In case of further witnesses please use separate sheet.

**5. Do you at present have any other Personal Accident policy?**

Yes  No (If yes, please complete the following)

Name & Address of the insurer and issuing office: \_\_\_\_\_

\_\_\_\_\_

Policy No. \_\_\_\_\_

Period: \_\_\_\_\_

Sum Insured: \_\_\_\_\_

**6. For which benefits do you claim? [Please tick (✓) the appropriate box]**

Benefit	Amount	Benefit	Amount
<input type="checkbox"/> Accidental Death		<input type="checkbox"/> Accident Hospital Cash	
<input type="checkbox"/> Permanent Total Disablement		<input type="checkbox"/> Accident Medical Expenses	
<input type="checkbox"/> Permanent Partial Disablement		<input type="checkbox"/> Accident Hospitalization (In-patient)	
<input type="checkbox"/> Temporary Total Disablement		<input type="checkbox"/> Accident Hospitalization (Out-patient)	
<input type="checkbox"/> Permanent Serious Disablement		<input type="checkbox"/> Broken Bones	
<input type="checkbox"/> Transportation of Mortal Remains		<input type="checkbox"/> Widowhood Cover	
<input type="checkbox"/> Cremation Ceremony		<input type="checkbox"/> Marriage Expenses for Children	
<input type="checkbox"/> Emergency Ambulance Charges		<input type="checkbox"/> Carrier	
<input type="checkbox"/> Education Fund		<input type="checkbox"/> Coma	
<input type="checkbox"/> Family Transportation		<input type="checkbox"/> Modification of Residence / Vehicle	
<input type="checkbox"/> Purchase of Blood		<input type="checkbox"/> Others	
<input type="checkbox"/> Transportation of Imported Medicine			
<input type="checkbox"/> Cost of Wheelchair / Crutches		<b>Total Claimed Amount</b>	

**Please attach the following documents [please tick (✓) the appropriate box]**

**List – I (Accidental Death)**

- Duly filled and signed Claim Form
- Policy copy
- Copy of FIR (First Information Report) /Spot Panchnama / Inquest Panchnama
- Death Certificate
- Original death summary
- Post Mortem Report
- Original legal heir certificate (in case nomination has not been filed by deceased)

**List – V (Emergency Ambulance Charges)**

- All documents of List – I or List - II , plus
- Original Bills and payment receipt
- Treating Doctor’s consultation indicating Emergency care

**List – II (Permanent Total Disablement/Permanent Partial Disablement/Temporary Total Disablement/ Permanent Serious Disablement)**

- Duly filled and signed Claim Form
- Policy Copy
- Copy of FIR (First Information Report)
- Original treating doctor certificate describing disablement
- Original Discharge summary from the hospital
- Original photograph of the injured reflecting disablement
- Prescription and consultation papers
- Leave certificate from the employer (If Employed)
- Disability Certificate issued by Civil Surgeon or equivalent as authorised by State Government
- Medical reports, case histories, investigation reports, treatment papers as applicable.

**List – VI (Education Fund)**

- All documents of List – I or List - II , plus
- Study Certificate from the school of the dependent child mentioning the parent’s name

**List – VII (Family Transportation)**

- All documents of List – I or List - II , plus
- Original Bills and payment receipt
- Proof of the immediate family member such as Ration Card

**List –VIII (Purchase of Blood)**

- All documents of List – I or List - II , plus
- Original Bills and payment receipt
- Prescription of the doctor mentioning the indication

**List – III (Transportation of Mortal Remains)**

- All Documents of List – I, plus
- Original Bills and payment receipt of transportation

**List – IX (Transportation of Imported Medicine)**

- All documents of List – I or List - II , plus
- Prescription of the doctor mentioning the indication
- Bill of Loading
- Original Medicine bill and payment receipt
- Reason for Import

**List – IV (Cremation Ceremony)**

- All Documents of List – I, plus
- Original Bills and payment receipt

**List –X (Cost of Wheel Chair / Crutches)**

- All documents of List - II , plus
- Original Bills and payment receipt
- Prescription of the doctor mentioning the indication

**List –XI (Accident Hospital Cash)**

- Duly filled and signed Claim Form
- Policy Copy
- Copy of the Discharge Summary
- Copy of First Information Report (FIR) / Medico-Legal certificate (MLC)
- If MLC not done, Treating doctor certificate giving details of Injury Sustained

**List –XII (Accident Medical Expenses / Hospitalization -Inpatient)**

- Same as the documents of List – II , plus
- Medical Bills with Prescription
- Medical Investigations report with prescription
- First Consultation and subsequent prescription

**List –XIII (Accident Hospitalization – Outpatient)**

- Same as the documents of List – XII except discharge summary

**List –XIV (Broken Bones)**

- Same as the documents of List – II , plus
- X-ray reports and films reflecting the fracture/s

**List –XV (Widowhood Cover)**

- Same as the documents of List – I , plus
- Marriage certificate

**List –XVI (Marriage Expenses for Children)**

- All documents of List – I or List - II , plus
- Proof of unmarried dependent Children [Affidavit and Age proof]

**List –XVII (Common Carrier)**

- Duly filled and signed Claim Form
- Policy Copy
- Original Ticket
- Copy of the Documents proving transportation of the Insured in the carrier

**List –XVIII (Coma)**

- Duly filled and signed Claim Form
- Policy Copy
- Copy of FIR (First Information Report)
- Prescription and consultation papers mentioning neurological findings
- Investigations report / neurological assessment report
- Clinical summary of the comatose patient from the treating Neurophysician /Neurosurgeon
- Proof of hospitalization

**List –XIX (Modification of Residence/Vehicle)**

- All documents of List - II , plus
- Original Bills and payment receipt

**7. Declaration**

I/We hereby warrant that:

- (1) I have read and understood the policy terms, conditions and exclusions
- (2) The foregoing particulars are true and complete in all material respects.

Date: \_\_\_\_\_ Place: \_\_\_\_\_

Signature of the Insured Person:

I/We hereby warrant that:

- (1) I have read and understood the policy terms, conditions and exclusions
- (2) The foregoing particulars are true and complete in all material respects.

Date: \_\_\_\_\_ Place: \_\_\_\_\_

Signature of the Policyholder:

**SECTION II To be completed by Nominee in the event of Policyholder's death**

Name of Nominee: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth (DD/MM/YYYY): \_\_\_\_\_ Relationship with the deceased: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Mobile No. \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Declaration to be signed by the Nominee (in the event of Insured's death)**

I/We hereby warrant that:

- (1) I have read and understood policy terms, conditions and exclusions and
- (2) That the forgoing particulars are true and complete in all material respects, and

I also authorise Apollo Munich Health Insurance Company Ltd to make payment of the claim admissible as per terms, conditions and limitations to the Insured Person or his legal heirs as full and final settlement. I/We will keep indemnified and hold Apollo Munich Health Insurance Company Ltd. harmless from any claim under this Policy by any third party.

Date: \_\_\_\_\_ Place: \_\_\_\_\_

Signature of the Nominee:

**SECTION III: To be completed by the Doctor who originally treated the injuries**

- 1) Name and address of the Injured Person: \_\_\_\_\_
- 2) Gender:  Male /  Female
- 3) Date of Birth (DD/MM/YYYY) and age: \_\_\_\_\_
- 4) Are you the patient's usual medical attendant?  Yes  No
  - a) If yes, since when (DD/MM/YYYY)? \_\_\_\_\_
  - b) If you have treated him/her for any previous illness or injury, please give details: \_\_\_\_\_
- 5) Has the patient sustained a similar injury previously or aggravated a pre-existing condition?  Yes  No
- 6) Describe nature and extent of injury: \_\_\_\_\_
  - a) If limb or eye is injured, please state whether right or left: \_\_\_\_\_
- 7) Nature and cause of accident (so far as it is known to you): \_\_\_\_\_
- 8) Are his/her injuries
  - a) Solely due to the accident?  Yes  No
  - b) Traceable to any disease, infirmity previous injuries or any other cause?  Yes  No
  - c) If yes please give details: \_\_\_\_\_
- 9) Injuries sustained in this accident are the sole cause of disablement? \_\_\_\_\_
- 10) Date you first examined the patient for this injury (DD/MM/YYYY): \_\_\_\_\_
 

If admitted in Hospital:  
 Date of Admission (DD/MM/YYYY): \_\_\_\_\_ Date of Discharge (DD/MM/YYYY): \_\_\_\_\_
- 11) According to you, how long should the injured person be confined to bed/house as the direct and sole consequence of the injury sustained?  
 From (DD/MM/YYYY) : \_\_\_\_\_ To (DD/MM/YYYY) : \_\_\_\_\_
  - a) During this period will the injured person be able to attend to his/her normal duties?
  - b) If yes, from what date (DD/MM/YYYY) : \_\_\_\_\_
  - c) If not, please state probable date of his/her being able to attend to his/her normal duties (DD/MM/YYYY) : \_\_\_\_\_
- 12) Is Claimant suffering from any disease or illness apart from his injury and is there any illness by circumstances which may tend to retard recovery?  Yes  No
  - a) If so: Give particulars: \_\_\_\_\_
- 13) Present Condition: \_\_\_\_\_
- 14) Was he/she under the influence of intoxicants or drugs at the time of accident? \_\_\_\_\_
- 15) Nature of disablement \_\_\_\_\_
  - a) Permanent Total Disablement  Yes  No
  - b) Permanent Partial Disablement  Yes  No
  - c) Please specify percentage: \_\_\_\_\_ %

I have personally examined the above named Insured Person. I certify that the above statements are correct and that the Insured Person is necessarily disabled by the Accident.

**Date:** \_\_\_\_\_ **Place:** \_\_\_\_\_

**Signature of the Doctor:** \_\_\_\_\_

**Name & Qualification:** \_\_\_\_\_

**Registration Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone No.:** \_\_\_\_\_ **Mobile No.:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**Stamp:**