HDFC ERGO General Insurance Company Limited

CRITICAL ILLNESS - 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.)

Please give the following information correctly and completely to enable us to process your claim promptly

1. Policy Number (in full)

2. HDFC ERGO Card No.
   (In case of Child Day 1 cover, please add the Card Number of the mother)

3. Name of the Insured (in whose name policy is issued)

   Mr. / Ms. / Mrs. (First Name) (Middle Name) (Last Name)

4. Details of the insured person (in respect of whose claim is made)

   i) Name of the Insured person:

   Mr. / Ms. / Mrs. (First Name) (Middle Name) (Last Name)

   ii) Relationship with the Insured

   iii) Date of Birth / Age DOB D D M M Y Y Y Y Age

   iv) Occupation

   v) Current Residential Address & Contact Details

   Address

   City Pincode

   State Sex Male Female

   Tel.(Res.) STD Code (Off.) STD Code Mobile

   E-mail

5. Have you previously from or received any treatment for the related illness? Y N

   If yes, give complete details _____

6. Date on which disease or illness frst detected D D M M Y Y Y Y

7. Details of treatment received including dates of outpatient or inpatient _____

8. Details of the doctor

   Mr. / Ms. / Mrs. (First Name) (Middle Name) (Last Name)

   Address

   City Pincode Qualifcation

   State Sex Male Female

   Tel.(Res.) STD Code (Off.) STD Code Mobile

9. Please give names and contact details of all doctors whom you have consulted

   Name Tel. STD Code

   Name Tel.

   Name Tel.

   Name Tel.

   Name Tel.

10. Please tick as (√) specifying the type of Critical Illness

- 1. Cancer ☐
- 2. Coronary Artery (Bypass) Surgery ☐
- 3. Heart Attack (Myocardial Infarction) ☐
- 4. Kidney Failure (End Stage Renal Failure) ☐
- 5. Major Organ Transplantation ☐
- 6. Multiple Sclerosis ☐
- 7. Paralysis ☐
- 8. Stroke ☐
- 9. Aorta Graft Surgery ☐
- 10. Primary Pulmonary Arterial Hypertension ☐
- 11. Heart Valve Replacement ☐
- 12. Benign Brain Tumor ☐
- 13. Parkinson's Disease ☐
- 14. Alzheimer's Disease ☐
- 15. End Stage Liver Disease ☐

11. No. of documents submitted including this CLAIM FORM _____

Declaration

I hereby warrant that:

(1) I have read and understood General Conditions 3 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 in respect of that may apply to this claim.

I also authorise HDFC ERGO to make payment of the claim admissible as per terms, conditions and limitations of the policy. I consent and authorise HDFC ERGO General Insurance Company or their representatives to seek medical information from any hospital/Medical practitioner who has at any time attended concerning the claim.

Place _____ Date _____

_____
Signature of the Claimant / Insured

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.

Check List of Enclosures for Submission of Claim

- ☐ Duly flled and signed Claim Form
- ☐ Photocopy of current year policy
- ☐ Copy of discharge summary of hospitalization, if any
- ☐ A medical certifcate confrming the diagnosis of critical illness from a doctor not less qualifed than MD/MS
- ☐ Investigation reports/ other related documents refecting the critical illness diagnosis
- ☐ First consultation letter and subsequent prescriptions

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Consent for Mode of Claim Payment

Name of Insured

Policy Number

Claim Number

Beneficiary Name

Mode of Payment (Please tick for mode of payment) Cheque ☐ Fund Transfer ☐

(All Fields are Mandatory in case of Fund Transfer)

Insured's Name as per Bank Account

Bank Account Number

Branch Name

IFSC Code

Email address

Attachments
In Support of Bank Details
(Please tick the type of proof submitted) Cancelled Cheque ☐ Bank Passbook Copy ☐

Declaration: I Mr./ Mrs/ Ms. _____ undersigned, legal beneficiary of the above claim, declare that all details mentioned in this form are true and I agree to the mode of payment against the particular claim number mentioned above.

Signature of Beneficiary
Stamp Required in case of Company

Date: D D M M Y Y Y Y