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

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 and other Insured Persons: _____

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 and 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 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-in 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 (incase 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

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

N. 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 to determine eligibility for benefit payments under the Policy Number identified above. I understand 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.

Date and Place: _____

Signature: _____

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: _____

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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: _____