

## HEALTH SURAKSHA - 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           Age

iv) Occupation

v) Current residential address & contact details

Address   
  
City  Pincode   
State  Sex Male  Female   
Tel.(Res.)   (Off.)   Mobile   
STD Code STD Code  
E-mail

5. Nature of disease/illness contracted or injury sustained \_\_\_\_\_

6. Date on which injury was sustained/disease or illness first detected

7. Type of Treatment  Allopathy  Unani  Ayurveda  Siddha  Homoeopathy

8. Details of the doctor

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

Address

City  Pincode  Qualification

State  Sex Male  Female

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

9. Details of the hospital

i) Inpatient Bill No.

ii) Name & address of the hospital/nursing home/clinic where treatment is taken/being taken

Name

Address

City  Pincode

State

iii) Date and time of admission in the hospital

iv) Date and time of discharge from the hospital

Insurance is the subject matter of solicitation

10. Please tick as (✓) specifying nature of claim as follows along with the Expense Details

| Details of expenses   | Amount     |
|---|------------|
| 1. In-patient Treatment <input type="checkbox"/>                    | Rs.        |
| a) General Hospitalization <input type="checkbox"/>                 | Rs.        |
| b) Organ Donor <input type="checkbox"/>                             | Rs.        |
| c) New Born baby <input type="checkbox"/>                           | Rs.        |
| d) Maternity Expenses <input type="checkbox"/>                      | Rs.        |
| e) Critical Illness <input type="checkbox"/>                        | Rs.        |
| 2. Pre Hospitalization <input type="checkbox"/>                     | Rs.        |
| 3. Post Hospitalization <input type="checkbox"/>                    | Rs.        |
| 4. Day care Expenses <input type="checkbox"/>                       | Rs.        |
| 5. Domiciliary Treatment <input type="checkbox"/>                   | Rs.        |
| 6. Emergency Ambulance <input type="checkbox"/>                     | Rs.        |
| 7. Outpatient Dental Treatment <input type="checkbox"/>             | Rs.        |
| 8. Spectacles, Contact Lenses, Hearing Aid <input type="checkbox"/> | Rs.        |
| 9. Convalescence Benefit <input type="checkbox"/>                   | Rs.        |
| 10. Hospital Daily Cash Benefit <input type="checkbox"/>            | Rs.        |
| 11. Health Check-up <input type="checkbox"/>                        | Rs.        |
| 12. Other benefits not included above <input type="checkbox"/>      | Rs.        |
| <b>Grand total</b>  | <b>Rs.</b> |

11. No. of documents submitted including this CLAIM FORM \_\_\_\_\_

12. Are you at present covered under any other similar type of insurance (Individual or Group Health Insurance, etc.)?

Yes  No

If yes, please give particulars of each (name of insurance company, policy number, begin of coverage, sum insured). \_\_\_\_\_

\_\_\_\_\_

### Declaration

I hereby warrant that

- (1) I have read and understood General Conditions Section 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 TPA and HDFC ERGO General Insurance Company Ltd to make payment of the claim admissible as per terms, conditions and limitations of the policy to the hospital on my behalf for full and final settlement of hospital bills (in case invoices are not paid).

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

#### In-patient Treatment /Day Care Procedures/ Ayush benefit

- Duly filled and signed Claim Form
- Photocopy of ID card / photocopy of current year policy
- Original detailed discharge summary / day care summary from the hospital
- Original consolidated hospital bill with break up of each item, duly signed by the insured
- Original payment receipt of the hospital bill
- First consultation letter and subsequent prescriptions
- Original bills, original payment receipts and reports for investigation
- Original medicine bills and receipts with corresponding prescriptions
- Original invoice/bills for implants (viz. Stent /PHS Mesh / IOL etc.) with original payment receipts

#### Road Traffic Accident

##### In addition to the In-patient Treatment documents

- Copy of the first information report from police department / copy of the medico-legal certificate

#### In Non Medico legal cases

- Treating doctor's certificate giving details of injuries (How, when and where injury sustained)

#### In Accidental Death cases

- Copy of post mortem report & death certificate

#### For Death Cases

##### In addition to the In-patient Treatment documents

- Original death summary from the hospital
- Copy of the death certificate from treating doctor or the hospital authority
- Copy of the legal heir certificate, if the claim is for the death of the principle insured

#### Pre- and Post-hospitalisation expenses

- Duly filled and signed Claim Form
- Photocopy of ID card / photocopy of current year policy
- Original medicine bills, original payment receipt with prescriptions
- Original investigations bills, original payment receipt with prescriptions and report
- Original consultation bills, original payment receipt with prescription
- Copy of the discharge summary of the main claim

#### Daily Cash /Convalescence Benefit

- Duly filled and signed Claim Form
- Photocopy of ID card / photocopy of current year policy

#### Ambulance Benefit

- Duly filled and signed Claim Form
- Photocopy of ID card / photocopy of current year policy
- Original bill with original payment receipt
- Treating doctor's consultation prescription indicating emergency hospitalization

#### Outpatient Benefit/Dental

- Duly filled and signed Claim Form
- Photocopy of ID card / photocopy of current year policy
- Original medicine bills and original payment receipts
- Original investigation bills, original payment receipts with reports
- Original consultation bills, original payment receipts with prescription
- Details of any outpatient procedures, if any
- Dental X-ray film

#### Organ Donor

##### In addition to the documents of general hospitalization

- Organ function test / blood test proving organ failure
- Treatment certificate issued by the transplant surgeon of the hospital concerned

#### Maternity Expenses

##### In addition to the In-patient Treatment documents:

- Obstetric history (Gravida, Para, Living children, Abortions) from treating doctor

#### Critical Illness Benefit

- Duly filled and signed Claim Form
- Photocopy of ID card / photocopy of current year policy
- A medical certificate confirming the diagnosis of critical illness from a doctor not less qualified than MD/MS
- Investigation reports/ other related documents reflecting the critical illness diagnosis

#### Expenses for spectacles/contact lenses, hearing aids

- Duly filled and signed Claim Form
- Photocopy of ID card / photocopy of current year policy
- Prescription of the treating doctor
- Original invoice/bills, original payment receipt of the device, appliances, lens etc

#### Health Check up

- Duly filled and signed Claim Form
- Photocopy of ID card / photocopy of current year policy
- Original investigation bills, original payment receipts with reports
- Original consultation bills and original payment receipts with prescription