

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

1. Policy Number (in full):						
2. Apollo Munich Health Member ID:						
3. Name of the Policyholder (in whose name policy is issued):						
4. Details of the Insured Person (in respect of whose clai	im is made):					
i) Name of the Insured person:						
ii) Relationship with the Policyholder:						
iii) Date of Birth /Age:						
iv) Occupation:						
v) Current Residential Address & Contact Details (Telephone/Mobile No./E-Mail):						
5. Nature of disease/illness contracted or injury sustaine	d:					
6. Date on which injury was sustained/disease or illness	first detected:					
7. Details of the Doctor:						
i) Name and address of the attending Medical Practitioner:						
ii) Qualification & telephone No.:						
8. Details of the Hospital:						
i)In-patientBillNo.:						
ii) Name & Address of the Hospital/Nursing Home/Clinic where treatment is taken/being taken:						
iii) Date (DD/MM/YYYY) and time(HH:MM) of Admission in the Hospital:						
iv) Date (DD/MM/YYYY) and time(HH:MM) of Discharge from the Hospital:						
9. Please tick as ($$) specifying nature of claim as follows along with the Expense Details						
Benefits	Per day Amount in Rs	No. of days hospitalised	Amount claimed			
🔲 12 i) Sicknoss Hospital Cash						

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	1a i) Sickness Hospital Cash			
	1a ii) Sickness ICU Cash			
	1b i) Accident Hospital Cash			
	1b ii) Accident ICU Cash			
	1c) Day Care Procedure Cash		NA	
	1d) Joint Hospitalisation due to an accident			
	le) Convalescence			
	1f) Child Birth		NA	
	1g) Parent Accommodation			
Total Amount Claimed				

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10. N	lo. of Documents submitted including this Claim Form:		
11. D)irect payment in your bank account (optional)		
P	lease provide the following details of your bank account and attach a cance	lled cheque pertaining to the sa	me account.
В	Bank Name Bank Branch		
B	lank Account Number	IFSC Code	MICR No
N	lote: It is agreed that the Policyholder/ Claimant will intimate in writing to A	pollo Munich Health Insurance C	o. Ltd. about any change in bank account details.
Decla	ration		
lh	ereby 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 respect:	s, and	
(3)) there is no other insurance in force in respect of that may apply to this clair	m.	
Pl	ace and Date:		
Si	gnature of the Claimant / Insured:		
Check	c List of Enclosures for Submission of Claim		
	Duly filled and signed Claim Form		
	Copy of current year Policy		
	Copy of detailed Discharge Summary from the Hospital*		
	Copy of First Consultation letter and subsequent Prescriptions*		
	Copy of Investigation reports*		
	Copy of Hospital Bill*		
	Copy of Obstetric history (Living Children)*		
*Docur	nents should be verified and attested by the hospital.		

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			

AMHI/PR/H/0018/0042B/102010/P