ApolloMunich HEALTH INSURANCE

Apollo Munich Health Insurance Co. Ltd.
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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
☐ Accidental Death		☐ Accident Hospital Cash	
☐ Permanent Total Disablement		☐ Accident Medical Expenses	
☐ Permanent Partial Disablement		☐ Accident Hospitalization (In-patient)	
☐ Temporary Total Disablement		☐ Accident Hospitalization (Out-patient)	
☐ Permanent Serious Disablement		☐ Broken Bones	
☐ Transportation of Mortal Remains		☐ Widowhood Cover	
☐ Cremation Ceremony		☐ Marriage Expenses for Children	
☐ Emergency Ambulance Charges		☐ Carrier	
☐ Education Fund		☐ Coma	
☐ Family Transportation		☐ Modification of Residence / Vehicle	
☐ Purchase of Blood		☐ Others	
☐ Transportation of Imported Medicine			
☐ Cost of Wheelchair / Crutches		**Total Claimed Amount**	

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 – 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 – III (Transportation of Mortal Remains)
- ☐ All Documents of List – I, plus
- ☐ Original Bills and payment receipt of transportation

List – IV (Cremation Ceremony)
- ☐ All Documents of List – I, plus
- ☐ Original Bills and payment receipt

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 – 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 – 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 –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:

AMHI/PA/0110