HDFC ERGO General Insurance Company Limited

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 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. Nature of disease/illness contracted or injury sustained _____

   _____

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

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.) STD Code (Off.) STD Code Mobile

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 D D M M Y Y Y Y H H M M

   iv) Date and time of discharge from the hospital D D M M Y Y Y Y H H M M

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

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

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 / pohotocopy 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