HDFC ERGO General Insurance Company Limited

Claim Form- Sampoorna Suraksha

CLAIM FORM – PART A
TO BE FILLED IN BY THE INSURED
The issue of this Form is not to be taken as an admission of liability

SECTION A – DETAILS OF PRIMARY INSURED

a) Policy No. b) Sl. No/ Certificate No: c) Company/ TPA ID No.

d) Name

e) Address

Phone No. Email ID

SECTION B – DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Medi Claim Health Insurance. Yes ☐ No ☐ b) Date of commencement of first insurance without break D D M M Y Y Y Y

c) If Yes, Company Name

Policy No. Sum Insured

d) Have you been hospitalized in the last four years since inception of the contract Yes ☐ No ☐ Date M M Y Y Y Y

Diagnosis

e) Previously covered by any other Medi Claim / Health Insurance Yes ☐ No ☐

f) If yes, Company Name

SECTION C- DETAILS OF INSURED PERSON HOSPITALISED

a) Name

b) Relationship ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother Other _____

c) Date of Birth D D M M Y Y Y Y d) Age Y Y M M

e) Address (If different than above)

f) Gender ☐ Male ☐ Female ☐ T/G g) Occupation: ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired Others _____

h) Telephone No I) Mobile No.

j) E-mail ID, if any

SECTION D- DETAILS OF HOSPITALISATION

a) Name of the Hospital where admitted

b) Room Category occupied ☐ Daycare ☐ Single Occupancy ☐ Twin Sharing ☐ 3 or more beds per room

c) Hospitalisation due to ☐ Illness ☐ Injury ☐ Maternity

d) Date of Injury/ Date of disease first detected/ Date of delivery D D M M Y Y Y Y e) Date of admission D D M M Y Y Y Y f) Time H H M M

g) Date of discharge D D M M Y Y Y Y h) Time H H M M

I) If injury, give cause ☐ Self-Inflicted ☐ Road Traffic Accident ☐ Substance Abuse ☐ Alcohol Consumption

i) If Medico legal Yes ☐ No ☐ ii) Reported to police? Yes ☐ No ☐ iii) MLC Report, & Police FIR attached? Yes ☐ No ☐

j) System of medicine ☐ Allopathic ☐ Other systems of medicine

SECTION E- DETAILS OF CLAIM (Applicable to my:health Suraksha, my:health Critical Suraksha Plus & my:health hospital cash add on)

a) Details of the treatment expenses claimed under Hospitalization Cover

i) Hospitalization Expenses		ii) Pre-hospitalisation Expenses	
iii) Post-hospitalization Expenses		iv) Ambulance Charges	
v) Organ Donor Expenses		vi) Air Ambulance Cover	
vii) Alternative Treatments		viii) Non Medical Expenses	
		Total	

b) Details of the treatment expenses claimed under Parent and Child Cover – Basic/Booster

i) Maternity Expenses		ii) Infertility Treatment Expenses	
iii) Pre natal/ Post Natal Expenses		iv) Vaccination Expenses	
v) New Born Baby Expenses			
		Total	

c) **Claim for Domiciliary Hospitalization** ☐ Yes ☐ No (if yes, please provide details in annexure)

d) **Claim for Preventive Health Check up** ☐ Yes ☐ No

Please tick the applicable Optional Cover cover claimed:

i) Hospital Cash		Please mention the number of days claimed for:	
ii) Major Illness Benefit		Please mention the Critical Illness claimed for:	
iii) E Opinion			
iv) Outpatient Dental Treatment			
v) External Medical Aids			

Applicable for my:health Critical Suraksha Plus

a) **Details of the treatment expenses claimed** _____

b) **Section under which claim is made** _____

Section A - Base Covers				
I - Critical Illness			**II - Multi pay Critical Illness**	
1	Cancer Cover	☐	Cancer Cover	☐
2	Heart Cover	☐	Heart Cover	☐
3	Nervous System Cover	☐	Nervous System Cover	☐
4	Other Major Organs Cover	☐	Other Major Organs Cover	☐

Section D - Optional Covers			
1	**Pre Diagnosis Cover**		
2	**Post Diagnosis Support**	Molecular Gene Expression Profiling Test	☐
		Post Diagnosis Assistance	☐
		Second Medical Opinion	☐
3	**Loss of Job Benefit**		☐

b) **Please provide the details**

i) Critical Illness / Multi Pay Critical Illness	☐	Please mention the Critical Illness claimed for:
Loss of Job		

Type of loss of Job	**Details along with Reason**	**Date**
Termination		
Dismissal / temporary suspension		
Retrenchment		
Resignation		

Claim Documents Submitted - Check List: Hospitalisation Claim		**Check list of additional documents for Critical Illness claims**
☐ Duly filled and signed Claim Form	☐ Copy of intimation letter, if any	☐ Medical certificate confirming the diagnosis of Critical Illness
☐ Hospital Main Bill	☐ Original Hospital bill break up	☐ Certificate from attending Medical Practitioner confirming the duration of illness
☐ Original Hospital Bill Payment Receipt	☐ Original Hospital Discharge summary	☐ First consultation letter and subsequent prescriptions
☐ Pharmacy Bill	☐ Operation theatre notes	☐ Indoor case papers if applicable
☐ Original Investigation / diagnostic Reports with original bills and payment receipt	☐ Doctors request for investigations	☐ FIR copy or medico legal certificate (wherever applicable)
☐ ECG	☐ Prescriptions	☐ Photo ID and Age proof
☐ Copy of the Network Provider's Registration Certificate	☐ MLC/FIR copy of applicable	☐ Death Summary with Death Certificate (In death claims only)
☐ KYC Documents	☐ implant stickers for all implants used during surgeries	☐ Original invoice for Vaccination and payment receipt

SECTION – F DETAILS OF BILLS ENCLOSED

S. No	Bill No.	Date						Issued By	Towards	Amount (Rs)						
		D	D	M	M	Y	Y									

SECTION G – DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN		b) Account Number	
c) Bank Name/ Branch		d) Payable details: Cheque/ DD	
e) IFSC Code		e) *please attach a cancelled cheque pertaining to the same	
f) MICR No		*please attach a cancelled cheque pertaining to the same	

Note: It is agreed that the Policyholder/Claimant will intimate in writing to HDFC ERGO General Insurance Co. Ltd. about any change in bank account details.
In an event Insured person bears expenses for treatment please provide account details of Insured Persons in the above format along with proof of incurring such expenses.

SECTION H – DECLARATION BY THE INSURED

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date: D D M M Y Y Y Y

Place:

Signature of Insured

GUIDANCE FOR FILLING CLAIM FORM–PARTA (To be filled in by the insured)		
DATAELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A- DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) SI. No / Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDAI and printed in TPA documents.
d) Name	Enter the full name of the policy holder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin Code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim/Health Insurance	Tick Yes or No
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name Enter	the full name of the insurance company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last 4 years	Indicate whether hospitalized in the last 4 years	Tick Yes or No
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Mediclaim/Health Insurance?	Indicate whether previously covered by another Mediclaim/Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policy holder	Tick the right option. If others, please specify.
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of Injury / Date Disease first detected / Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) If Injury give cause	Indicate cause of injury	Tick the right option

If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
SECTION E – DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum / cash benefit claimed	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
d) Claim Documents Submitted - Check List	Indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amount sin rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) Cheque / DD pay abled etails	Enter the name of the beneficiary the cheque / DD should be made out to	Name of the individual / or ganization in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (indd:mm:yy format), place (open text) and sign.		

HDFC ERGO General Insurance Company Limited

Claim Form- Sampoorna Suraksha

CLAIM FORM – PART B
TO BE FILLED IN BY THE HOSPITAL

The issue of this Form is not to be taken as an admission of liability
Please include the original preauthorisation request form in lieu of PART A

SECTION A – DETAILS OF HOSPITAL

a) Name of the Hospital where treated
b) Hospital ID
c) Type of Hospital
Network
Non Network (If non network fill section E)
d) Name of the treating Doctor
e) Qualification
f) Registration No with state Code
g) Phone No:

SECTION B – DETAILS OF PATIENT ADMITTED

a) Name of the patient
b) IP Registration Number
c) Gender ☐ Male ☐ Female
d) Date of Birth D D M M Y Y Y Y
e) Age Y Y M M
f) Date of Admission D D M M Y Y Y Y
g) Time of Admission H H M M
h) Date of Discharge D D M M Y Y Y Y
I) Time of Discharge H H M M
j) Type of Admission ☐ Emergency ☐ Planned ☐ Daycare ☐ Maternity
k) If Maternity
i) Date of Delivery D D M M Y Y Y Y
ii) Gravida Status D D M M Y Y Y Y
k) Status at time of discharge ☐ Discharged to Home ☐ Discharged to another Hospital ☐ Deceased
l) Total Claimed Amount

SECTION C – DETAILS OF AILMENTS DIAGNOSED (PRIMARY)

a) ICD 10 Codes	Primary Diagnosis		Additional Diagnosis		Co-morbidities	
Details of Procedure/s done						
b) ICD 10 PCS	Procedure 1		Procedure 2		Procedure 3	
c) Pre-authorization obtained	☐ Yes ☐ No		d) Pre-authorization No.			
e) If authorization by network hospital not obtained, give reason						
f) Hospitalisation due to Injury	☐ Yes ☐ No		g) If yes, give cause			
Self inflicted?	☐ Yes ☐ No	Road Traffic Accident	☐ Yes ☐ No	Substance Abuse / Alcohol Consumption	☐ Yes ☐ No	

ii) If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: ☐ Yes ☐ No (If yes, attach reports)
iii) Medico Legal ☐ Yes ☐ No
iv) Reported to Police ☐ Yes ☐ No
v) FIR No
vi) If not reported to Police give reasons

SECTION D – CLAIM DOCUMENTS SUBMITTED – CHECKLIST

☐ Claim form duly filled and signed	☐ Investigation reports
☐ Original Pre authorization Request	☐ CT/MRI/USG/HPE investigation Report
☐ Copy of Pre-authorization approval Letter	☐ Doctor's reference slip for Investigation
☐ Copy of photo ID card of patient verified by Hospital	☐ ECG
☐ Hospital Discharge Summary	☐ Pharmacy Bills
☐ Operation Theatre Notes	☐ MLC Report & Police FIR
☐ Hospital Main Bill	☐ Original death summary from hospital where applicable
☐ Hospital break up Bill	☐ Any other, Pl specify

SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL

Address of the Hospital
Phone No.
Registration No. with State Code
Hospital PAN
No of In-patient Beds
Facilities available in Hospital: ☐ OT ☐ ICU ☐ Others

SECTION F – DECLARATION BY HOSPITAL

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: D D M M Y Y Y Y

Place:

Signature and seal of the Hospital Authority

GUIDANCE FOR FILLING CLAIM FORM – PART B (TO BE FILLED IN BY THE HOSPITAL)

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A – DETAILS OF HOSPITAL		
a) Name of Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether In network or non network Hospital	Tick the right option
d) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor alongwith the state code	As allocated by the Medical Council of India or the equivalent Authority in the country of hospitalization
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B – DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh: mm format
g) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh: mm format
i) Type of Admission	Indicate type of admission of patient	Tick the right option
j) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
k) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Present Ailmentisa Complication of PED	Indicate whether present ailment is a complication of some pre-existing disease	Tick Yes or No
d) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
e) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
f) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization Number	Open text
g) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No

SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY) (CONTD.)

Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption, test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported To Police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open text

SECTION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST

Indicate which supporting documents are submitted

SECTION E – ADDITIONAL DETAILS IN CASE OF NON NET WORK HOSPITAL

a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No.	Enter the registration number of patient	As allocated by the Hospital
d) PAN	Enter the permanent account number	As allotted by the Income Tax department
e) Number of Inpatient Beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify

SECTION F – DECLARATION BY THE INSURED

Read declaration carefully and mention date (indd:mm:yyformat), place (open text) and sign.

SECTION G – DECLARATION BY THE HOSPITAL

Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

Note:

1. When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organisation / provider have to be submitted.
2. If original bills, receipts, prescriptions, reports and other documents are submitted to Us and Insured Person requires same for claiming from other organisation / provider, then on request from the Insured Person We will provide attested copies of the bills and other documents submitted by the Insured Person.
3. If below mentioned documents are not provided in full or are insufficient for **Us** to consider the claim, then **We** may request additional information or documentation.

In-patient Treatment /Day Care Procedures

- ☐ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.
- ☐ Original Detailed Discharge Summary with date of admission & discharge, clinical history, past history / procedure details / 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/Sticker of implants / 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 (If conducted)

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.

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM (CONTD.)

Pre and Post-hospitalization 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 documents and bills, original payment receipt with prescription.
- ☐ Copy of the Discharge Summary of the main claim.

Organ Donation / Transplantation

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.

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.

Critical Illness Benefit

- ☐ Duly filled and signed Claim Form.
- ☐ Medical certificate confirming the diagnosis of Critical Illness
- ☐ Certificate from attending Medical Practitioner confirming that the duration of Illness
- ☐ Discharge certificate / card from the Hospital, if any
- ☐ Investigation test reports confirming the diagnosis
- ☐ First consultation letter and subsequent prescriptions
- ☐ Indoor case papers if applicable
- ☐ Specific documents to confirm the diagnosis of respective Critical Illness
- ☐ In the cases where Critical Illness arises due to an accident, FIR copy or medico legal certificate, wherever conducted.

Hospital Cash Benefit

- ☐ Duly filled and signed Claim Form.
- ☐ Discharge card / day care summary / transfer summary
- ☐ Final Hospital Bill
- ☐ Previous consultation papers indicating history and treatment details for current ailment.
- ☐ Diagnostic test reports (including imaging and laboratory) along with the Medical prescription & copy of invoice / bill and receipt from the diagnostic centre.
- ☐ MLC / FIR copy – in Accidental cases only
- ☐ Death summary & death certificate (in death claims only)

Preventive Health Check up

- ☐ Duly filled and signed Claim Form.
- ☐ Health check up test reports Original bill and receipt from the diagnostic

Documents for Critical Illnesses Cover, Multi pay Critical Illness Cover

- ☐ Claim Form duly signed by the Insured Person;
- ☐ Copy of Discharge Summary / Discharge Certificate;
- ☐ First consultation letter from treating Medical Practitioner
- ☐ Medical certificate confirming diagnosis, and the treatment from Medical Practitioner
- ☐ certificate from treating Medical Practitioner, specifying the duration and etiology
- ☐ OT Notes in case of Surgery
- ☐ Medical certificate from treating Medical Practitioner specifying the diagnosis and need for the surgery
- ☐ MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable
- ☐ All pathological and radiological Investigation Reports
- ☐ NEFT details & cancelled cheque
- ☐ Provide KYC (Know your customer) form along with photocopy of any one of following KYC documents for all claims amounting to Rs 1 lakh and above (Aadhaar Card, Passport, Driving Licence Voter ID, etc

Documents and process for Second Expert medical Opinion

- ☐ Duly filled claim form along with the copy of all medical reports including investigation reports and discharge summary (if any) Consultation fees payment Receipt / invoice

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM (CONTD.)

Documents for loss of Job

- ☐ Duly Completed Claim Form signed by Insured Person;
- ☐ Form 16A
- ☐ Termination letter/Resignation Letter/ Resignation Acceptance letter
- ☐ NEFT details & cancelled cheque

Hospitalization Claim documents under Super Top up Policy

- ☐ Claim Form Duly filled with requisite information and signed by Insured & Hospital
- ☐ Copy of the claim intimation
- ☐ Original Hospital Main Bill
- ☐ Original Hospital Bill break up (Where issued by the Hospital)
- ☐ Original Hospital Bill Payment Receipt
- ☐ Hospital Discharge Card/Summary
- ☐ Original Pharmacy Bill with supporting prescriptions
- ☐ Medical Investigation report: ECG/X-Ray/USG/CT/MRI/Histopathology/pathological and all other medical investigation report in support of diagnosis as advised by the treating doctor.
- ☐ All Doctor's consultation note: confirming provisional & final diagnosis / advise for admission/medical complication/proposed line of treatment/past medical history
- ☐ Original bills and receipts for claiming Ambulance charges (if any)
- ☐ By signing the claim form you are authorizing us to collect the following documents from the Hospital. If you have obtained these documents, then please submit the same
- ☐ Operation Theatre Notes in surgical cases
- ☐ Bar code sticker & Invoice for implants and prosthesis (if used)
- ☐ In case of Accidental Injuries, Medico Legal Certificate and / or First information Report, where applicable and self-statement giving description of the incident
- ☐ Indoor case papers

Pre and Post hospitalization Claims documents under Super Top up

- ☐ Duly filled claim form(s)(If claimed Separately)
- ☐ Pharmacy Bills with supporting prescriptions
- ☐ Medical investigation test reports and payment receipts with doctor's advice note for such investigations.
- ☐ All Doctor's consultation note with original bills and receipts for claiming Doctors fees

CUSTOMER IDENTIFICATION PROCEDURE (AS PER KYC NORMS OF IRDAI)

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

SECTION 5: PERSONAL ACCIDENT

Accidental Death and Permanent Total Disability	
Date of accident _____	Place accident occurred _____
Particulars of the accident /Description of accidental details	_____
Was the accident related to the Insured's occupation? Yes ☐ No ☐	Whether reported to Police station? Yes ☐ No ☐
In case hospitalized list the name and address of all treating physicians and hospital	_____
Please indicate whether claim is in respect of	Accidental Death Permanent Total Disability
For Accidental Death	
Date of Accident _____	Place of Death _____
For child education Benefit: Provide details of dependent child	Date of Birth Child 1 _____ Date of Birth Child 2 _____
For Permanent Total Disability	Details of permanent disablement:

Accidental Hospitalisation / Hospital Cash	
Date and time of accident _____	Place accident occurred _____
Particulars of the accident / Description of accidental details	_____
Date of admission _____ Date of Discharge _____	Whether reported to Police station? Yes ☐ No ☐
Particulars of the accident /Description of accidental details	_____
Please describe the nature of Insured's injuries	From _____ To _____
Name and address of all treating physicians and hospital	_____
Date Insured able to return to work	_____

Temporary Total Disability/ Broken Bones/ Accidental Injury	
Date and time of accident _____	Place accident occurred _____
Particulars of the accident /Description of accidental details	_____
Date of admission _____ Date of Discharge _____	Whether reported to Police station? Yes ☐ No ☐
Details of Temporary disablement	_____
Dates of Temporary disablement	From _____ To _____
Name and address of all treating physicians and hospital	_____
Date Insured able to return to work	_____

Claimant's Name

Relationship to Insured

Claimant's Address

City State Pin Code

Mobile Alternate no

Date: D D M M Y Y Y Y

Place:

Signature of claimant

LIST OF DOCUMENTS

***Photocopy of Aadhaar Card / Aadhaar Card number is mandatory for all claims Personal Accident - Death**

- ☐ Duly filled and signed Claim Form
- ☐ FIR from Police station/ Medico legal certificate from hospital (MLC Copy)
- ☐ Post Mortem Report, Inquest Panchnama
- ☐ Cause of death Certificate from treating doctor
- ☐ Death Certificate from Municipal Corporation
- ☐ Histopathology or Chemical viscera or blood analysis report from the hospital (If done)
- ☐ KYC form and KYC documents (ID and address proof e.g Pan card/Aadhaar card/Ration card/Passport etc.)
- ☐ Original cancelled cheque with name of Nominee printed on cheque is required. If name is not printed on cheque please attach first page of bank passbook / Bank statement with stamp

Personal Accident - Permanent Disability

- ☐ Duly filled and signed Claim Form
- ☐ FIR from Police station/ Medico legal certificate from hospital (MLC Copy)
- ☐ Disability Certificate from Government Hospital
- ☐ All treatment papers and Investigation report from hospital
- ☐ Photograph with disable part
- ☐ KYC form and KYC documents (ID and address proof e.g Pan card, Aadhaar card, Ration card, Passport etc.)
- ☐ Original cancelled cheque with Payee name (Insured) name printed on cheque is required. If name is not printed on cheque please attach first page of bank passbook/Bank statement with bank stamp

Accidental Hospitalization Benefit / Hospital cash benefit

- ☐ Duly filled and signed claim form
- ☐ FIR from Police station/ Medico legal 3. certificate from hospital (MLC Copy)
- ☐ Copy of discharge summary of hospitalization, if any
- ☐ KYC form and KYC documents (ID and address proof e.g Pan card, Aadhaar card, Ration card, Passport etc.)
- ☐ Original Hospital Final Bill with payment receipt, Original Medicine Bills, Prescriptions. Original Investigation reports and bills
- ☐ Original cancelled cheque with Payee name (Insured / Nominee) name printed on cheque is required. If name is not printed on cheque please attach first page of bank passbook /Bank statement with bank stamp

Temporary total disablement / Broken bones /Accidental injury

- ☐ Duly signed filled claim form
- ☐ Discharge card / summary from hospital
- ☐ Investigation report like X-RAY/ MRI / CT scan etc. if any
- ☐ Fitness certificate from treating doctor
- ☐ Leave certificate from employer (If or are salaried) or ITR of last 2 yrs if business men
- ☐ KYC form and KYC documents (ID and address proof e.g Pan card, Aadhaar card, Ration card, Passport etc.)
- ☐ Original cancelled cheque with Payee name (Insured) name printed on cheque is required. If name is not printed on cheque please attach first page of bank passbook / Bank statement with stamp

Section 6: Travel Insurance

Does the insured have any other Healths / Accident or Travel Insurance? If yes, please give details below:

Name of Insurer

Policy Number Amount (Rs)

Date trip commenced Schedule date of return

Passport No Trip Destination

Claims Ref No

In what capacity are you making this claim?

Please indicate whether claim is in respect of (Tick Boxes)

☐ Accidental Death ☐ Permanent Disability ☐ Emergency Medical Expenses ☐ Emergency Dental Treatment ☐ Hospital Cash ☐ Baggage Loss

☐ Baggage Delay ☐ Trip Cancellation/ Interruption ☐ Personal Liability ☐ Any Other

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by HDFC General Insurance, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I also authorize International SOS to obtain any medical records or information to process this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Date: D D M M Y Y Y Y

Place:

SIGNED (Claimant or authorized person)

N.B. Please complete appropriate section of Claim Form and read carefully the instructions relating to supporting documents required. When completed please sign declaration above.

SECTION A: ACCIDENTAL INJURY CLAIM (CIAIMANT'S STATEMENT)

Time and Place accident occurred

Please describe in detail the circumstances of accident (attach separate sheet if needed):

Please describe the nature of Insured's Injuries:

Please list the names and addresses of all treating physicians and hospitals:

Name

Street Address

City State Pin Code

Phone No.

Did police or other authorities investigate the accident? _____

If yes, please provide name, address and telephone number of all investigating officers and agencies: _____

SECTION B: EMERGENCY MEDICAL EXPENSES EMERGENCY DENTAL EXPENSES (INSURED'S STATEMENT)

Name of Sickness or Injury

Place of Sickness / Injury

Date of sickness / injury D D M M Y Y Y Y Circumstances of Sickness / Injury

Nature of Sickness / Injuries

If claim was due to hospitalization was SOS Assistance contacted? Yes ☐ No ☐

If 'NO', please advice on separate sheet.

Please list the names and addresses of all treating physicians and hospitals:

Name

Street Address

City State Pin Code

Phone No.

Admitted on: Discharged on:

SECTION C: ACCIDENTAL INJURY / MEDICAL EXPENSES CIAIM (ACCIDENT OR SICKNESS) ATTENDING PHYSICIAN'S STATEMENT

Date of accident/sickness. D D M M Y Y Y Y Date of first treatment: D D M M Y Y Y Y

Please describe in detail the nature of the Insured's injuries

Was the Insured hospitalized? Yes ☐ No ☐

If yes, please list the names and addresses of all hospitals and all admission discharge dates:

Name

Address

City State Pin Code

Phone No.

Admitted on: Discharged on:

Did the Insured have any injury or illness prior to the accident that contributed to the accident or to the Insured's present condition?

If yes, please describe:

Were any surgical procedures performed? Yes ☐ No ☐

If yes, please list all procedures, and dates performed: _____

What are the Insured's current subjective symptoms? _____

What are the objective findings? (Please include results of current x-rays, lab tests, etc.)? _____

Dates of total disability: From D D M M Y Y Y Y To D D M M Y Y Y Y

Dates of partial disability: From D D M M Y Y Y Y To D D M M Y Y Y Y Date insured able to return to work: D D M M Y Y Y Y

Was the Insured seen by any other physician? Yes ☐ No ☐

If yes, please list the names and addresses of all other physicians:

Name

Street Address

City State Pin Code

Phone No.

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician:

Address

City State Pin Code

Phone No.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud

Place:

Date: D D M M Y Y Y Y

SIGNED (Attending Physician)

SECTION D : BAGGAGE PROTECTION / BAGGAGE DELAY CLAIM INFORMATION

Date of loss, damage or delay D D M M Y Y Y Y Time of day H H M M a.m/p.m.

Please describe in detail where and how the loss, damage or delay occurred: _____

Please describe in detail the nature and extent of loss, damage or delay: _____

Was loss, damage or delay occurred while insured property was on or in the custody of a common carrier (e.g., railroad, airline, cruise ship, bus, taxi, etc.)? ☐ Yes ☐ No

If yes, please complete the following:

Name of carrier: _____ Flight, trip or Tour Number: _____

Was the carrier notified at the time of the loss or damage? ☐ Yes ☐ No

If yes, please identify where, when and to whom (Name and Title) notification was given: _____

Was extra valuation on property declared? _____

If yes, how much? _____

Was baggage checked at the time of loss or damage? ☐ Yes ☐ No

If yes, please enclose claim check:

Has formal claim been filed against the carrier? ☐ Yes ☐ No

If yes, has payment been made to you? ☐ Yes ☐ No If yes, amount received?

Do you have any other insurance that may provide coverage for this accident or loss? ☐ Yes ☐ No

If yes, please identify Name, Address and Policy Number of all other insurance including homeowners, travel club, credit cards, etc.: _____

Has a claim been filed? ☐ Yes ☐ No If yes, what is the current status of that claim?

Was loss reported to police or other authorities? ☐ Yes ☐ No

If yes, please identify where, when and to whom (name and title) loss was reported: _____

Case # _____

Valuation of lost and or damaged property

Sr. No.	Description	Date of Purchase	Place of Purchase	Original Cost	Replacement Cost or Estimate	Amount Claimed
1		D D M M Y Y Y Y				
2		D D M M Y Y Y Y				
3		D D M M Y Y Y Y				
4		D D M M Y Y Y Y				
5		D D M M Y Y Y Y				
6		D D M M Y Y Y Y				

(attachbills of sale, receipts or estimates)

Are any claims item used in your business/ occupation or profession? If yes, identify the item(s) by * above _____

SECTION E : FLIGHT DELAY CLAIM INFORMATION

Name of the Common Carrier:

Flight No.: From D D M M Y Y Y Y To D D M M Y Y Y Y

Schedule time of Departure Actual time of Departure Date of Cancellation (if applicable): D D M M Y Y Y Y

Reason of Delay cancellation: No. of hours delayed:

Did you miss any connecting flight due to the above delay? ☐ Yes ☐ No

If yes, kindly give details: _____

Name of the Common Carrier:

Flight No.: From D D M M Y Y Y Y To D D M M Y Y Y Y Schedule time of Departure

Did you receive any compensation from the Common Carrier? ☐ Yes ☐ No

If yes, kindly give details: _____

Do you have any other insurance that may provide coverage for this delay? ☐ Yes ☐ No

If yes, please provided Name, Address and Policy Number of all insurance includes travel club, credit card, etc.:_____

_____

Has a claim been filled? ☐ Yes ☐ No If yes, what is the status of that claim?_____

Details of The Expenditure Incurred

Sr. No.	Description of Items	Date	Place	Amount
1		D D M M Y Y Y Y		
2		D D M M Y Y Y Y		
3		D D M M Y Y Y Y		
4		D D M M Y Y Y Y		
5		D D M M Y Y Y Y		
			Total	

Discharge Voucher

Claim Number: Policy Number:

We here by discharge HDFC ERGO General Insurance Company on any future liability on the claim; upon receipt of sum of Rupees _____ from HDFC ERGO General Insurance Company Ltd. as full and final settlement.

Name

Date: D D M M Y Y Y Y

Authorized Signatory

Company Stamp

*** Please note on receipt of this Discharge Voucher, HDFC ERGO General Insurance Company Ltd. shall dispatch the claim cheque to you***.

If yes, what is the status of that claim? _____

SECTION 7: HOME INSURANCE

(For Losses other than under Personal Accident and Public Liability Insurance)

(N.B. To be filled in by the Insured Policyholder or Insured's authorized representative enjoying power of attorney. Issuance of this claim form is not be taken as admission of liability)

Policy No.: Client No.:

Insured Details

Name

Address

City State Pin Code

Phone No. Fax No.

E-mail

Details of Loss or Damage

Date: D D M M Y Y Y Y Time: H H M M a.m./p.m. Place:

1. Section under which loss is being claimed _____
2. (a) State the circumstances of the loss or damage: _____
   (b) Give details of extent of loss or damage suffered, itemwise. _____
3. When and where did you last see the lost or damaged property? _____
4. On what day and at what hour did you first discover the loss or damage? _____
5. If any third party was responsible for the loss or damage, give name and address. _____
   _____
6. Have you informed the Police Authorities? If so, when and where?
   Police Station _____ Diary No. _____
7. Are you the sole owner of the property damaged or stolen? _____
8. Are there any other insurances upon the same property ? If so give particulars
   Policy No. _____ Insurance Company : _____
   Address: _____
   _____

Damage to Buildings/Contents :

9. Full description of lost or damaged articles. _____
10. Estimated cost of repairs/replacement _____
11. When and where can the damaged items be inspected? _____

I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and I/We agree if I/We have made, or in any further declaration the Company may require in respect of the said loss, shall make any false or fraudulent statement, or any suppression or concealment the Policy shall be void and all rights to recover thereunder in respect of past or future accidents shall be forfeited.

Place:

Date: D D M M Y Y Y Y

Signature of the Insured

SECTION 8 : e@Secure INSURANCE

A. Details of the Policyholder

Reported under Policy Number/ Certificate:

Name

Address

City State Pin Code

Phone No. Fax No.

Email

B. Details of Claim and Circumstance

(a) Date on which policyholder first become aware of facts or circumstances that might give rise to a loss. _____

(b) Actual date of loss: _____

(c) Date of intimation to the insurer : _____

(d) Event resulted into loss

(i) Damage to e-reputation ☐ (ii) Identity theft ☐ (iii) Unauthorized online transactions ☐ (iv) E-extortion ☐

(v) Cyber bullying ☐ (vi) Email spoofing ☐ (viii) Protection of Digital Assets from malware (Optional Cover) ☐

(e) Detailed description of the acts in chronological order which has resulted into the loss _____

(f) Estimated quantum of loss: _____

(g) Provide the insurer with periodic and timely updates concurrent with activity taking place during the covered incident.

(h) Any additional details about which Policyholder wishes to advice, or which may be of interest to the insurer, so that the insurer will have a better understanding of this matter? If so, please provide details along with supporting documentation.

(i) Attach the copy of any internal or external survey/investigation and all such relevant reports, if any.

C. Bank details of the Policyholder for claim payment- Annexure- A

D. Preliminary documents required at the time of claim intimation

a. Copy of FIR lodged with Police Authorities / Cyber cell
b. Copies of legal notice received from any affected person/entity
c. Copies of summon received from any court in respect of a suit filed by an affected party/entity
d. Copies of invoices for expenses You incurred for the services of IT specialist
e. Copies of invoices for expenses You incurred in amending / rectifying Your Personal Information
f. Evidence of Your consultation with Psychologist / Psychiatrist
g. Evidence of unpaid wages
h. Copy of Your last drawn monthly salary.
i. Evidence of expenses incurred by You in rectifying records regarding your identity
j. Copies of correspondence with bank evidencing that bank is not reimbursing You
k. Based on the information submitted in the claim intimation letter, if required, we may procure more information from you depending on the facts mentioned therein up to the satisfaction of the insurer.

D. Declaration

I/We (Print Name in full) _____

(Position): _____

of the Policyholder and on behalf of the Policyholder declare the above answers to be true and correct AND acknowledge that the insurer may make its decision on indemnity having regard to these answers.

- We acknowledge: Nothing in this form amends, alters or waives any of the provisions of the policy. Acceptance of this form is not acceptance of any claim by HDFC ERGO.
- We agree that the settlement should be made in favour of and payable to the insured / beneficiary as per details mentioned in Annexure-A.

Date: D D M M Y Y Y Y

Signature

Please attach a separate sheet wherever required for giving the details.

Note:

Send Notice of Claims To:

The Manager
Claims Department
HDFC ERGO General Insurance Company Limited
6th Floor Leela Business Park, Andheri Kurla Road, Andheri East, Mumbai - 400059, India

Customer Service No: 022 - 6234 6234 / 0120 - 6234 6234

Such notice shall be effective on the date of receipt by the Company at such address