EASY HEALTH
CLAIM FORM

ApolloMunich HEALTH INSURANCE
Apollo Munich Health Insurance Co. Ltd.
10th Floor, Tower-B, Building No. 10, DLF Cyber City, DLF City Phase -II, Gurgaon, Haryana-122002

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 :

1. **Policy Number (in full):** _____
2. **Apollo Munich Health Card No.:** _____
   (In case of Child Day 1 cover: Please add the Card Number of the mother.)
3. **Name of the Policyholder (in whose name the Policy is issued):** _____
4. **Details of the Insured Person (in respect of whose claim is made):**
   - i) **Name of the Insured Person:** _____
   - ii) **Relationship with the Policyholder:** _____
   - iii) **Date of Birth /Age:** _____ **(DD/MM/YYYY)** _____ **Years**
   - iv) **Occupation:** _____
   - v) **Current Residential Address :** _____

     _____

     _____

     _____

     Contact Details (Telephone/Mobile No./E-Mail): _____

     _____
5. **Nature of disease/illness contracted or injury sustained:** _____
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-patient Bill No.:** _____
   - 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:**

     _____

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

	Details of Expenses	Amount
☐	In-patient Treatment	Rs. _____
	a) General Hospitalization	Rs. _____
	b) Organ Donation /Transplantation	Rs. _____
	c) New Born baby	Rs. _____
	d) Maternity	Rs. _____
	e) Critical Illness	Rs. _____
☐	Pre Hospitalization	Rs. _____
☐	Post Hospitalization	Rs. _____
☐	Day care Expenses	Rs. _____
☐	Domiciliary Treatment	Rs. _____
☐	Daily Cash for choosing shared accommodation	Rs. _____
☐	Emergency Ambulance	Rs. _____
☐	Daily Cash for accompanying an insured child	Rs. _____
☐	Other expenses not included above	Rs. _____
	Grand total	**Rs.** _____

10. No. of documents submitted including this Claim Form: _____

11. Are you at present covered under any other similar type of insurance (Individual or Group Health Insurance, etc.)? [Y / N]
If Yes, please give particulars of each (name of insurance company, policy number, policy inception date, sum insured).

_____

_____

_____

12. Direct payment in your bank account (optional)

Please provide the following details of your bank account and attach a cancelled cheque pertaining to the same account.

Bank Name _____ Bank Branch _____

Bank Account Number _____ IFSC Code _____ MICR No. _____

Note: It is agreed that the Policyholder/Claimant will intimate in writing to Apollo Munich Health Insurance Co. Ltd. about any change in bank account details.

Declaration

I hereby declare and warrant that:

(1) I have read and understood the Policy terms, conditions and exclusions, and

(2) The foregoing particulars are true and complete in all material respects, and

(3) There is no other insurance in force that may apply to this claim.

I also authorise the TPA and Apollo Munich Health Insurance Co. Ltd. to make payment of any claim or part of a claim found to be admissible as per the terms, conditions and limitations of the Policy to the hospital on my behalf as full and final settlement of any liability under the Policy. I will keep indemnified and hold Apollo Munich Health Insurance Co. Ltd. harmless from any claim under this Policy by any third party, including any hospital or other place from which treatment has been taken or services obtained.

Place and Date: _____

Signature of the Claimant / Insured: _____

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Check List of Enclosures for Submission of Claim

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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 / 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.

Outpatient Benefit/Dental

- ❑ Duly filled and signed Claim Form.
- ❑ Photocopy of ID card / Photocopy of current year policy.
- ❑ Original Medicine bills, original payment receipt.
- ❑ Original Investigations bills, original payment receipt with report.
- ❑ Original Consultation bills, original payment receipt with prescription.
- ❑ Details of any Outpatient Procedures, If any
- ❑ Dental X-ray film.

Daily Cash Benefit

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

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.

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.

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.

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.

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