HDFC ERGO General Insurance Company Limited

Claim Form - my:credit Comprehensive 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

Policy No. | Sl. No/ Certificate No: | Company/ TPA ID No

Name

Address

Phone no | Email ID

SECTION B – DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim 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 D D M M Y Y Y Y

Diagnosis

e) Previously covered by any other Mediclaim / 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 M M Y Y

e) Address (If different than above)

f) Gender ☐ Male ☐ Female 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) Date of Injury/ Date of disease first detected/ Date of delivery D D M M Y Y Y Y c) Date of admission D D M M Y Y Y Y d) Time H H M M

e) Date of discharge D D M M Y Y Y Y f) Time H H M M

g) 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 ☐

i) MLC Report & Police FIR attached? Yes ☐ No ☐ ii) System of medicine ☐ Allopathic ☐ Other systems of medicine

SECTION E- DETAILS OF CLAIM

a) Details of the treatment expenses claimed for

b) Section under which claim is made

Section	Cover	
1	Critical Illness Cover	Yes ☐ No ☐
2	Women Suraksha	Yes ☐ No ☐
3	Sachet Critical Illness cover	Yes ☐ No ☐
4	Recovery Benefit	Yes ☐ No ☐
5	Assault and Burns	Yes ☐ No ☐
6	Hospital Cash	Yes ☐ No ☐
7	Permanent Total Disablement - Illness	Yes ☐ No ☐

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Optional Covers

Section	Cover	
1	Pregnancy and New Born Complications	Yes ☐ No ☐
2	Pre Diagnosis Cover	Yes ☐ No ☐
3	Preventive Health check-up	Yes ☐ No ☐
4	Post Diagnosis Assistance	Yes ☐ No ☐
5	Molecular Gene Expression Profiling Test	Yes ☐ No ☐
6	Second Medical Opinion - India	Yes ☐ No ☐
7	Second Medical Opinion - Global	Yes ☐ No ☐
8	Loss of Job	Yes ☐ No ☐
9	Cardiac Arrest	Yes ☐ No ☐
10	Recovery Benefit – Global	Yes ☐ No ☐
11	Post Trauma Assistance	Yes ☐ No ☐
12	Hospital Cash – Global	Yes ☐ No ☐
13	Companion Benefit	Yes ☐ No ☐
14	ICU Hospitalization	Yes ☐ No ☐
15	Maternity Benefit	Yes ☐ No ☐
16	Waiting Period Modification Option	Yes ☐ No ☐
17	Time deductible Options	Yes ☐ No ☐
18	Reinstatement of cover	Yes ☐ No ☐

c) Please provide the below details

i) Critical Illness / Surgeries	☐	Please mention the Critical Illness/Surgeries claimed for:
ii) Hospital Cash	☐	Please mention the no of days, benefit claimed for

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) Payee Name		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	
g) PAN Number :			

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

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 organization/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 organization/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.

Claims Documents for Critical Illness/Surgical Procedure and Permanent Total Disablement due to Illness.

- ☐ Duly filled Claim Form with signature of claimant.
- ☐ Copy of Discharge Summary / Discharge Certificate / Death Certificate (in case insured expired);
- ☐ 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/Histopathological and radiological Investigation Reports
- ☐ NEFT details & cancelled cheque of Claimant or Nominee (in case claimant expired), Provide legal heir certificate in case nominee is minor.

  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 License Voter ID, etc)

Claims Documents for Hospital cash and Recovery Benefit

- ☐ Claim Form duly signed by the Insured Person
- ☐ Copy of Discharge Summary / Discharge Certificate along with time of admission and discharge for hospital cash benefit
- ☐ First consultation letter from treating Medical Practitioner
- ☐ certificate from treating Medical Practitioner, specifying the duration and etiology
- ☐ MLC/FIR copy/ certificate regarding abuse of Alcohol / intoxicating agent if applicable
- ☐ NEFT details & cancelled cheque of Claimant or Nominee (in case claimant expired), Provide legal heir certificate in case nominee is minor.

Claims documents and procedure for Second Opinion

- ☐ Duly filled claim form along with the copy of all medical reports including investigation reports and discharge summary (if any)
- ☐ Select Our network Medical Practitioner from whom you would prefer to take the second opinion. (Please refer our Website or call at 24X7 toll free line to obtain the list of Our panel doctors).
- ☐ On receipt of the complete set of documents, We will forward the same to the concerned doctor.
- ☐ The Second Opinion shall be forwarded to the member within 15 working days of receipt of the complete set of documents.

Claims 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 of Claimant or Nominee (in case claimant expired), Provide legal heir certificate in case nominee is minor.

Please mention the type of Loss of Job

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

Claims documents for Post Diagnosis Counseling

- ☐ Claim Form duly signed by the Insured Person
- ☐ Consultation papers

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