HDFC ERGO General Insurance Company Limited

Claim Form

my: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 mediclaim health insurance	YES / NO
b) Date of commencement of first insurance without break	DD/MM/YYYY
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: MM/YYYY
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) Age	__mths/yrs
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) Room Category occupied		Daycare/Single Occupancy/Twin Sharing/ 3 or more beds per room	
c) Hospitalization due to		Illness / Injury/ Maternity	
d) Date of Injury/ Date of disease first detected/ Date of delivery		DD/MM/YYYY	
e) Date of admission		DD/MM/YYYY	
f) Time		HH/MM	
g) Date of discharge		DD/MM/YYYY	
h) Time		HH/MM	
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

HDFC ERGO General Insurance Company Limited. IRDAI Reg. No. 146. CIN: U66030MH2007PLC177117. Registered & Corporate Office: 6th Floor, Leela Business Park, Andheri-Kurla Road, Andheri (East), Mumbai – 400 059. Health Claim Services Address: HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower - 1, 5th Floor, C - 25, Noida, Sector 62, 201301, Uttar Pradesh. Service No. 022 6158 2020/022 6234 6234. Email: healthclaims@hdfcergo.com. UIN: my:Sampoorna Suraksha - HDFHLIP21562V012021.

HDFC ERGO General Insurance Company Limited

Claim Form

my:Sampoorna Suraksha

SECTION E- DETAILS OF CLAIM (Applicable to my:health Suraksha, my:health Critical Suraksha Plus, my:health hospital cash add on & my:health Koti Suraksha – Personal Accident)			
a) Details of the treatment expenses claimed under Hospitalization Cover			
i) Hospitalization Expenses		ii) Pre-hospitalization 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:	

HDFC ERGO General Insurance Company Limited

Claim Form

my:Sampoorna Suraksha

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

Applicable to my:health Koti Suraksha – Personal Accident			
i) Accidental Death	YES / NO	viii) Chauffeur Benefit	YES / NO
ii) Permanent Total Disablement	YES / NO	ix) Emergency Medical Expense	YES / NO
iii) Temporary Total Disablement	YES / NO		
iv) Hospital Cash – Accident Only	YES / NO		
v) Broken Bones	YES / NO		
vi) Burns	YES / NO		

Optional Cover under Hospital Cash- Accident Only					
i) Companion Benefit		YES / NO			
ii) Time Deductible Modification Option		YES / NO			
iii) Hospital Cash - ICU		YES / NO			
Hospital Cash – Accident - Global		YES / NO			
Please tick the applicable Optional Cover claimed under Personal Accident Cover:					
i) Preventive Health Check Up		YES / NO			
ii) Last Rites		YES / NO			
iii) Medical Evacuation- illness & accident		YES / NO			
iv) Dependent Child Education Benefit	YES / NO				
v) Renewal premium Benefit	YES / NO				
vi) Parental Care Benefit	YES / NO				
Claim Documents Submitted- Check List: Hospitalisation Claim	Check list of additional documents for Critical Illness claims				

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

HDFC ERGO General Insurance Company Limited

Claim Form

my:Sampoorna Suraksha

SECTION – F DETAILS OF BILLS ENCLOSED																
Sno	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: **Place** **Signature of Insured**

GUIDANCE FOR FILLINGCLAIM FORM–PARTA(Tobe filled inbytheinsured)		
DATAELEMENT	**DESCRIPTION**	**FORMAT**
SECTIONA- DETAILSOFPRIMARYINSURED		
a) PolicyNo.	Enter thepolicynumber	As allotted bytheinsurancecompany
b) SI.No/CertificateNo.	Enter thesocialinsurancenumber or the certificate number of socialhealth insurancescheme	As allotted bytheorganization
c) CompanyTPAIDNo.	Enter theTPAIDNo	Licensenumber as allottedbyIRDAI and printedinTPA documents.
d) Name	Enter thefullnameofthepolicyholder	Surname,Firstname,Middlename
e) Address	Enter thefullpostal address	IncludeStreet, CityandPinCode

HDFC ERGO General Insurance Company Limited

Claim Form

my:Sampoorna Suraksha

SECTIONB- DETAILSOF INSURANCEHISTORY		
a) Currentlycovered byanyotherMediclaim/ HealthInsurance?	Indicatewhethercurrentlycoveredby anotherMediclaim /HealthInsurance	TickYesorNo
b) Date of Commencementoffirst Insurancewithoutbreak	Enter thedate ofcommencementoffirstinsurance	Usedd-mm-yyformat
c) CompanyName	Enter thefullnameoftheinsurancecompany	Nameoftheorganizationin full
PolicyNo.	Enter thepolicynumber	As allotted bytheinsurancecompany
Sum Insured	Enter thetotalsum insuredasperthepolicy	Inrupees
d) Have you beenHospitalizedinthelast4years	Indicatewhetherhospitalizedinthelast4years	TickYesorNo
Date	Enter thedate ofhospitalization	Use mm-yy format
Diagnosis	Enter thediagnosis details	OpenText
e) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim /Health Insurance	TickYesorNo
f) CompanyName	Enter thefullnameoftheinsurancecompany	Nameoftheorganizationin full
SECTIONC- DETAILSOFINSURED PERSON HOSPITALIZED		
a) Name	Enter thefullnameofthepatient	Surname,Firstname,Middlename
b) Gender	IndicateGender ofthe patient	TickMaleor Female
c) Age	Enter age ofthe patient	Number ofyearsandmonths
d) DateofBirth	Enter Date ofBirth ofpatient	Usedd-mm-yyformat
e) RelationshiptoprimaryInsured	Indicaterelationship ofpatientwithpolicyholder	Ticktherightoption.Ifothers,pleasespecify.
f) Occupation	Indicateoccupationofpatient	Ticktherightoption.Ifothers,pleasespecify.
g) Address	Enter thefullpostal address	IncludeStreet, CityandPinCode
h) PhoneNo	Enter thephone number ofpatient	IncludeSTDcode withtelephonenumber
i) E-mailID	Enter e-mailaddressofpatient	Completee-mailaddress
SECTIOND- DETAILSOFHOSPITALIZATION		
a) NameofHospitalwhereadmitted	Enter thename ofhospital	Nameofhospitalin full
b) Roomcategoryoccupied	Indicatetheroom categoryoccupied	Ticktherightoption
c) Hospitalizationdueto	Indicatereason ofhospitalization	Ticktherightoption
d) DateofInjury/Date Diseasefirstdetected/ Dateof Delivery	Enter therelevant date	Use dd-mm-yy format
e) Dateofadmission	Enter date ofadmission	Use dd-mm-yy format
f) Time	Enter time ofadmission	Use hh:mm format
g) Dateofdischarge	Enter date ofdischarge	Use dd-mm-yy format
h) Time	Enter time ofdischarge	Use hh:mm format
i) IfInjurygivecause	Indicatecause ofinjury	Tick the right option
IfMedicolegal	Indicatewhetherinjuryismedico legal	Tick Yes or No
ReportedtoPolice	Indicatewhether policereportwasfiled	Tick Yes or No
MLCReport&Police FIRattached	Indicatewhether MLCreportandPoliceFIR attached	Tick Yes or No
j) System ofMedicine	Enter thesystem ofmedicinefollowed in treating thepatient	OpenText
SECTION E – DETAILS OF CLAIM		
a) Details ofTreatmentExpenses	Enter theamountclaimedas treatment expenses	In rupees(Do not enter paise values)
b) Claim for DomiciliaryHospitalization	Indicatewhetherclaimisfordomiciliary hospitalization	TickYesorNo
c) Details ofLumpsum/cashbenefitclaimed	Enter theamountclaimedas lumpsum/ cashbenefit	In rupees(Do not enter paise values)

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d) Claim DocumentsSubmitted-CheckList	Indicate which supporting documents are submitted	Ticktherightoption
SECTIONF -DETAILSOFBILLSENCLOSED		
Indicatewhichbillsare enclosed withtheamountsin rupees		
SECTIONG -DETAILSOFPRIMARYINSURED'SBANKACCOUNT		
a) PAN	Enter thepermanentaccountnumber	As allotted bythe IncomeTax department
b) AccountNumber	Enter thebankaccountnumber	As allotted bythebank
c) BankNameand Branch	Enter thebank namealong withthebranch	NameoftheBankinfull
d) Cheque/DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Nameoftheindividual/organizationinfull
e)IFSCCode	Enter the IFSCcodeofthebank branch	IFSC codeofthebank branchinfull
SECTIONH- DECLARATIONBYTHEINSURED		
Read declaration carefully and mention date(in dd:mm:yy format),place(open text)and sign.		

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 pre-authorization request form in lieu of PART A

SECTION A – DETAILS OF HOSPITAL			
a) Name of the Hospital where treated		a) Hospital ID	
b) Type of Hospital	Network	Non Network (If non network fill section E)	
c) 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) Age	YY/MM
a) Date of Birth	DD/MM/YYYY		
f) Date of Admission	DD/MM/YYYY	g) Time of Admission	HH/MM
h) Date of Discharge	DD/MM/YYYY	i) Time of Discharge	HH/MM
j) Type of Admission	Emergency/Planned/Daycare/ Maternity	k) If Maternity	
i) Date of Delivery	DD/MM/YYYY	ii) Gravida Status	
l) Status at time of discharge	Discharged to Home Discharged to another Hospital Deceased	Total Claimed Amount	

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	
e) Pre-authorization obtained	Y/N		f) Pre-authorization No			
f) If authorization by network hospital not obtained, give reason						
g) Hospitalisation due to Injury	YES / NO		i) 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:	Y/N (If yes, attach reports		iii) Medico Legal		YES / NO	

my:Sampoorna Suraksha

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			
a) Address of the Hospital		b) Phone NO:	
c) Registration no with State Code		d) Hospital PAN	
e) No of In-patient Beds		f) Facilities available in Hospital	
i) OT	Y/N	ii) ICU	Y/N
iii) 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:	Place:	Signature and seal of the Hospital Authority

GUIDANCE FOR FILLINGCLAIM FORM–PART B(To be filled in by the hospital)		
DATAELEMENT	**DESCRIPTION**	**FORMAT**
SECTIONA- DETAILSOFHOSPITAL		
a) NameofHospital	Enter the name of hospital	Name of hospital in full
b) HospitalID	Enter ID number of hospital	As allocated by the TPA
c) TypeofHospital	Indicate whether In network or non network Hospital	Tick the right option
d) Nameoftreatingdoctor	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) RegistrationNo.withStateCode	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India or the equivalent Authority in the country of hospitalization
g) PhoneNo.	Enter the phone number of doctor	Include STD code with telephone number
	SECTIONB– DETAILSOFTHEPATIENT ADMITTED	
a) NameofPatient	Enter thenameofhospital	Nameofhospitalinfull
b) IPRegistrationNumber	Enter insuranceproviderregistrationnumber	As allottedbytheinsuranceprovider
c) Gender	IndicateGenderofthepatient	TickMaleorFemale
d) Age	Enter age ofthepatient	Numberofyearsandmonths
e) DateofAdmission	Enter date ofadmission	Usedd-mm-yyformat
f) Time	Enter time ofadmission	Usehh:mmformat

my:Sampoorna Suraksha

g) DateofDischarge	Enter date ofdischarge	Usedd-mm-yyformat
h) Time	Enter time ofdischarge	Usehh:mmformat
i) TypeofAdmission	Indicatetypeofadmissionofpatient	Ticktherightoption
j) IfMaternity		
DateofDelivery	Enter Date ofDeliveryifmaternity	Usedd-mm-yyformat
GravidaStatus	Enter Gravidastatusifmaternity	Usestandardformat
k) Statusattimeofdischarge	Indicatestatusofpatientattimeofdischarge	Ticktherightoption

SECTIONC– DETAILSOFAILMENTDIAGNOSED(PRIMARY)		
a) ICD10Code		
PrimaryDiagnosis	Enter the ICD10Code anddescriptionof the primary diagnosis	Standard FormatandOpentext
AdditionalDiagnosis	Enter the ICD10Code anddescriptionofthe additional diagnosis	Standard FormatandOpentext
Co-morbidities	Enter the ICD10Code anddescriptionofthe-co-morbidities	Standard FormatandOpentext
b) ICD10PCS		
Procedure 1	Enter the ICD10PCSand description of the-firstprocedure	Standard FormatandOpentext
Procedure 2	Enter the ICD10PCSand description of the-secondprocedure	Standard FormatandOpentext
Procedure 3	Enter the ICD10PCSand description of theth-irdprocedure	Standard FormatandOpentext
Details ofProcedure	Enter thedetailsoftheprocedure	Opentext
c) PresentAilmentisaComplicationof PED	Indicatewhetherpresentailmentisacomplica-tionofsomepre-existing disease	TickYesorNo
d) Pre-authorization obtained	Indicatewhetherpre-authorization obtained	TickYesorNo
e) Pre-authorizationNumber	Enter pre-authorization number	As allottedbyTPA
f) Ifauthorizationbynetworkhospitalnotob-tained,give reason	Enter reasonfornotobtainingpre-authorization-number	Opentext
g) Hospitalizationduetoinjury	Indicateifhospitalizationisduetoinjury	TickYesorNo
Cause	Indicatecauseofinjury	Ticktherightoption
Ifinjury duetosubstanceabuse/alcoholcon-sumption,testconductedtoestablishthis	Indicatewhethertestconducted	TickYesorNo
Medico Legal	Indicatewhetherinjuryismedico legal	TickYesorNo
ReportedToPolice	Indicatewhetherpolicereportwasfiled	TickYesorNo
FIRNo.	Enter firstinformationreportnumber	Asissuedbypoliceauthorities
Ifnotreported topolice,givereason	Enter reasonfornotreportingtopolice	OpenText
SECTIOND– CLAIM DOCUMENTSSUBMITTED-CHECK LIST		
Indicatewhichsupportingdocumentsaresubmitted		
SECTIONE– ADDITIONAL DETAILS INCASEOFNONNETWORKHOSPITAL		
a) Address	Enter thefullpostal address	IncludeStreet, CityandPinCode
b) PhoneNo.	Enter thephonenumber ofhospital	IncludeSTDcodewithtelephonenumber
c) RegistrationNo.	Enter theregistrationnumberof patient	AsallocatedbytheHospital
d) PAN	Enter thepermanentaccountnumber	As allottedbytheIncomeTaxdepartment
e) NumberofInpatientBeds	Enter thenumberofinpatientbeds	Digits
f) Facilitiesavailableinthehospital	Indicatefacilitiesavailableinthe hospital	Ticktherightoption.Ifothers,pleasespecify
SECTIONF -DECLARATIONBYTHEINSURED		
Read declarationcarefullyandmentiondate(indd:mm:yyformat),place(opentext)and sign.		
SECTIONG -DECLARATIONBYTHEHOSPITAL		
Read declarationcarefullyandmentiondate(indd:mm:yyformat),place(opentext)and signandstamp		

HDFC ERGO General Insurance Company Limited

Claim Form

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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 Wemay 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.

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.

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.

my:Sampoorna Suraksha

- 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

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

HDFC ERGO General Insurance Company Limited

Claim Form

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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

Documents for my:health Koti Suraksha – Personal Accident

Accidental Death

1. Medical Practitioner's Report
2. Medico Legal Certificate
3. Death certificate
4. Post mortem/FSL (Forensic science laboratory)report – To check for drug abuse/intoxication

Permanent Disablement

1. Medical Practitioner's Report
2. Medico Legal Certificate
3. Investigation Reports like Laboratory test, X-rays and reports essential of confirmation of the Injury;
4. Disability certificate from a government certified Medical Practitioner or government Hospital confirming the extent and nature of disability;
5. Original Discharge summary from the Hospital Medical reports, case histories, investigation reports, treatment papers as applicable.
6. Letter from treating Medical Practitioner mentioning the reason and date for disablement and confirming the disablement.

Temporary Total Disablement

1. Medical Practitioner's Report
2. Medico Legal Certificate
3. Investigation Reports like Laboratory test, X-rays and reports essential of confirmation of the Injury;
4. Original Discharge summary from the Hospital
5. Medical reports, case histories, investigation reports, treatment papers as applicable.

6. Letter from treating Medical Practitioner mentioning the reason and date for disablement and confirming the disablement. And advised days of rest.
7. Leave certificate from the employer (If Employed)
8. Fitness certificate from Medical practitioner Insured's own Indian bank cancelled cheque copy and bank details in attached format

Hospital Cash- Accident Only

1. Copy of Discharge Summary / Discharge Certificate along with time of admission and discharge for Hospital cash benefit
2. First consultation letter from treating Medical Practitioner
3. Certificate from treating Medical Practitioner, specifying the duration and etiology
4. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable
5. NEFT details & cancelled cheque of Claimant or Nominee (in case claimant expired), Provide legal heir certificate in case nominee is minor.

Broken Bones

1. Medical Practitioner's Report
2. Investigation Reports like Laboratory test, X-rays and reports essential of confirmation of the Injury;
3. Disability certificate from a government certified Medical Practitioner or government hospital confirming the extent and nature of disability;
4. Original Discharge summary from the hospital
5. Medical reports, case histories, investigation reports, treatment papers as applicable.
6. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable
7. Relevant treatment papers clearly mentioning the areas of fracture with their severity.

Burns

1. Attested copy of certificate from treating Medical Practitioner specifying type of burns with percentage of burns
2. Attested copy of FIR. (If any)
3. All X-Ray / Investigation reports and films supporting to disability.

Medical Evacuation

1. Consultation note or Emergency Room's Medical Practitioner medical report
2. Copy of the passport showing the date of entry and exit related to journey (to & fro) from India.
3. All relevant Original Invoices for the expenses incurred towards ambulance facility.
4. A covering letter from claimant mentioning the details of loss.

Emergency Medical Expenses

1. Consultation note or Emergency Room's Medical Practitioner medical report.
2. Relevant treatment papers or Discharge Summary.
3. Copy of the passport showing the date of entry and exit related to journey (to & fro) from India.
4. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable
5. All relevant Original Invoices for the expenses incurred.

Dependent Child Education Benefit

1. Consultation Note OR Emergency Room's Medical Practitioner medical report OR
2. Relevant Treatment Papers OR Discharge Summary. .
3. Letter from treating Medical Practitioner, mentioning the cause of death if death occurred after a long period from the date of incident.
4. Disability certificate from a government certified Medical Practitioner or government hospital confirming the extent and nature of disability;
5. Death certificate
6. Final police investigation report
7. Post-mortem Report or Coroner's Report
8. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable.

Section 6: Travel Insurance

Does the insured have any other Health / 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……..……

HDFC ERGO General Insurance Company Limited

Claim Form

my:Sampoorna Suraksha

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.

SIGNED (Claimant or authorized person)……..

PLACE…….DATE……..

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

Section A: Accidental Injury Claim (Claimant'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

Circumstances of Sickness/Injury? .....

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Claim Form

my:Sampoorna Suraksha

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 Claim (Accident or Sickness) Attending Physician's Statement

Date of accident/sickness: …… Date of first treatment:……

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

Was the Insured hospitalized? Ye s No

If yes, pleaselist the names and addresses of all hospitals and all admission/discharge dates:

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……. To……..

Dates of partial disability: From……. To……..

Date insured able to return to work: ……

Was the Insured seen by any other physician? Ye s No
If yes, pleaselist the names and addresses of all other physicians:

Attending Physician Information

Name of Attending Physician:
Address:…….Phone No……..

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

SIGNED (Attending Physician)

Place…… Date…….

HDFC ERGO General Insurance Company Limited

Claim Form

my:Sampoorna Suraksha

Section D :Baggage Protection / Baggage delay claim Information

Date of loss, damage or delay…….. Time of day …….. 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, pleasecomplete 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, pleaseencloseclaim check:

Has formalclaim 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, travelclub, 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 and place of purchase	Original Cost	Replacement Cost orEstimate	Amount Claimed
1					
2					
3					
4					
5					
6					

my:Sampoorna Suraksha

(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…… To……..

Schedule time of Departure……. Actual time of Departure……..

Date of Cancellation (if applicable):…….

Reason of Delayƒcancellation:……..

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…….. To……

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 includestravelclub, 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				
2				
3				

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 finalsettlement.

Authorized Signatory with Name Date Company Stamp

*** Please note on receipt of this Discharge Voucher, HDFC ERGO General Insurance Company Ltd. shall dispatch the claimcheque to you***.
If yes, what is the status of that claim?

HDFC ERGO General Insurance Company Limited

Claim Form

my:Sampoorna Suraksha

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 ……. Phone No……..Fax No…….e-mail……..

Details of Loss or Damage

Date …….Time ……..AM/PM 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 ordamaged articles.
10. Estimated cost of repairs/replacement
11. When and where can the damageditems 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 ofthe said loss, shall make any false or fraudulent statement, or any suppression or concealment the Policy shall be void andall rights to recover thereunder in respect of past or future accidents shall be forfeited.

Date: Signature of the Insured
Place:

Section 8: E@secure Insurance

A. Details of the Policyholder

(a) Reported under Policy Number/ Certificate:
(b) Name & Address of the Policyholder:……..
(c) Phone:….. Fax No…….
(d) 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 □

my:Sampoorna Suraksha

(ii) Identity theft □
(iii) Unauthorized online transactions □
(iv) E-extortion □
(v) Cyber bullying □
(vi) Email spoofing □
(vii) Phishing □
(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.

Signature

Date

HDFC ERGO General Insurance Company Limited

Claim Form

my:Sampoorna Suraksha

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