HDFC ERGO General Insurance Company Limited

Group Critical Illness Insurance

CLAIM FORM

To be filled in by the Insured
The issue of this form is not to be taken as an admission of liability

(To be filled in block letters)

SECTION A – DETAILS OF PRIMARY INSURED

a) Policy No.: b) Sl. No/ Certificate No.:

c) Company/ TPA ID No.:

d) Name: SURNAME FIRSTNAME MIDDLENAME

e) Address:

City: State:

Pin Code: Phone No.: Email ID:

f) Employee No. g) HEGIC No.

I) Policy Holder / Employer Name SURNAME FIRSTNAME MIDDLENAME

SECTION B - DETAILS OF INSURANCE HISTORY

a) Currently covered by any other mediclaim health insurance/ Critical Illness Insurance: ☐ Yes ☐ No b) Date of commencement of first insurance without break: DD MM YYYY

c) If Yes, Company Name: Policy No.:

Sum Insured (Rs): d)Have you been hospitalized/diagnosed for such Critical Illness earlier? ☐ Yes ☐ No Date: MM YY

Diagnosis:

e) Previously covered by any other Mediclaim/Health insurance/ Critical Illness Insurance: ☐ Yes ☐ No f) If Yes, Company Name:

SECTION C - DETAILS OF INSURED PERSON HOSPITALISED

a) Name: SURNAME FIRSTNAME MIDDLENAME

b) Relationship to primary Insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ Please Specify:

c) Date of Birth: DD MM YYYY d) Age: YY MM

e) Address (if different from above)

f) Gender: Male ☐ Female ☐

g) Occupation: Service ☐ Self employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ Please Specify:

City: State: Pin Code:

h) Phone No.: i) Mobile No.: j) Email ID:

SECTION D - DETAILS OF CLAIM

Please tick as (√) specifying the type of Critical Illness

First Heart Attack of Specified Severity	☐	Stroke	☐
Major Organ/ Bone Marrow Transplantation	☐	Aorta Graft Surgery	☐
Kidney Failure (End Stage Renal Disease)	☐	Multiple Sclerosis	☐
Open Heart Valve Replacement	☐	Permanent paralysis of Limbs	☐
Major Burns	☐	Deafness	☐
Open Chest CABG	☐	End Stage Liver Disease	☐
Coma	☐	Loss of Speech	☐
Cancer of specified severity	☐	Benign Brain Tumor	☐
Primary Parkinson's Disease	☐	Alzheimer's Disease	☐

Date of which Critical Illness first detected? DD MM YYYY

Have you made a claim for the same Critical illness with any other insurer earlier? ☐ Yes ☐ No

Has your Claim for this Critical illness rejected by any other insurer? ☐ Yes ☐ No

Claim Documents Submitted- Check List:

- ☐ Duly filled and signed Claim Form
- ☐ Copy of intimation letter, if any
- ☐ Medical Practitioner's Request for Investigation
- ☐ Medical Practitioner's Prescription
- ☐ Indoor Case Papers/Treatment papers
- ☐ Hospital Discharge Summary
- ☐ Consultation Notes
- ☐ Operation Theater Notes
- ☐ Investigation Reports (Including CT, MRI/USG/HPE/ECG)
- ☐ Specialist Medical Practitioner's Report confirming Diagnosis of Critical Illness
- ☐ Copy of Medico legal certificate
- ☐ First Information Report/Final Police Report
- ☐ Death Certificate/Death Summary/Post mortem Report
- ☐ Details of Consultations/ Treatment received?
- ☐ Number of Documents Submitted including this claim form
- ☐ Others

SECTION E - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN: b) Account Number:

c) Bank Name/ Branch:

d) Payable details: Cheque/ DD:

*e) IFSC Code: *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 F – 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 / insurer, 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 included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except pre/post hospitalization claim, if any

Date: Place:

Signature of Insured /Nominee/
Insured's legal heir (in case of insured's death)

GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)

DATA ELEMENT	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 IRDA and printed in TPA documents.
d) Name	Enter the full name of the policyholder	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 policyholder	Tick the right option. If others, please
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please
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 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

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)

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 payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization 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 (in dd:mm:yy format), place (open text) and sign.		

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