

HDFC ERGO General Insurance Company Limited



CRITICAL ILLNESS - CLAIM FORM

(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.)

Please give the following information correctly and completely to enable us to process your claim promptly

1. Policy Number (in full)

2. HDFC ERGO Card No.
(In case of Child Day 1 cover, please add the Card Number of the mother)

3. Name of the Insured (in whose name policy is issued)

Mr. / Ms. / Mrs.
(First Name) (Middle Name) (Last Name)

4. Details of the insured person (in respect of whose claim is made)

i) Name of the Insured person:

Mr. / Ms. / Mrs.
(First Name) (Middle Name) (Last Name)

ii) Relationship with the Insured

iii) Date of Birth / Age DOB Age

iv) Occupation

v) Current Residential Address & Contact Details

Address

City Pincode
State Sex: Male Female
Tel.(Res.) (Off.) Mobile
STD Code STD Code
E-mail

5. Have you previously from or received any treatment for the related illness? Y N

If yes, give complete details: _____

6. Date on which disease or illness first detected

7. Details of treatment received including dates of outpatient or inpatient: _____

8. Details of the doctor

Mr. / Ms. / Mrs.
(First Name) (Middle Name) (Last Name)
Address

City Pincode Qualification
State Sex: Male Female
Tel.(Res.) (Off.) Mobile
STD Code STD Code

9. Please give names and contact details of all doctors whom you have consulted

Name <input type="text"/>	Tel.(Res.) <input type="text"/> <input type="text"/>
	STD Code
Name <input type="text"/>	Tel.(Res.) <input type="text"/> <input type="text"/>
	STD Code
Name <input type="text"/>	Tel.(Res.) <input type="text"/> <input type="text"/>
	STD Code
Name <input type="text"/>	Tel.(Res.) <input type="text"/> <input type="text"/>
	STD Code
Name <input type="text"/>	Tel.(Res.) <input type="text"/> <input type="text"/>
	STD Code

10. Please tick as (✓) specifying the type of Critical Illness

- | | |
|---|--------------------------|
| 1. Cancer | <input type="checkbox"/> |
| 2. Coronary Artery (Bypass) Surgery | <input type="checkbox"/> |
| 3. Heart Attack (Myocardial Infarction) | <input type="checkbox"/> |
| 4. Kidney Failure (End Stage Renal Failure) | <input type="checkbox"/> |
| 5. Major Organ Transplantation | <input type="checkbox"/> |
| 6. Multiple Sclerosis | <input type="checkbox"/> |
| 7. Paralysis | <input type="checkbox"/> |
| 8. Stroke | <input type="checkbox"/> |
| 9. Aorta Graft Surgery | <input type="checkbox"/> |
| 10. Primary Pulmonary Arterial Hypertension | <input type="checkbox"/> |
| 11. Heart Valve Replacement | <input type="checkbox"/> |
| 12. Benign Brain Tumor | <input type="checkbox"/> |
| 13. Parkinson's Disease | <input type="checkbox"/> |
| 14. Alzheimer's Disease | <input type="checkbox"/> |
| 15. End Stage Liver Disease | <input type="checkbox"/> |

11. No. of documents submitted including this CLAIM FORM _____

Declaration

I hereby warrant that:

- (1) I have read and understood General Conditions 3 of this policy, and
- (2) That the foregoing particulars are true and complete in all material respects, and
- (3) There is no other insurance in force in respect of that may apply to this claim.

I also authorise HDFC ERGO to make payment of the claim admissible as per terms, conditions and limitations of the policy, I consent and authorise HDFC ERGO General Insurance Company or their representatives to seek medical information from any hospital/Medical practitioner who has at any time attended concerning the claim.

Place _____

Date _____

Signature of the Claimant / Insured

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.

Check List of Enclosures for Submission of Claim

- Duly filled and signed Claim Form
- Photocopy of current year policy
- Copy of discharge summary of hospitalization, if any
- 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
- First consultation letter and subsequent prescriptions
- Original cancelled cheque with payee name printed on the cheque is required. If name of payee is not printed on the cheque please attach copy of the first page of bank passbook

HDFC ERGO General Insurance Company Limited



Consent for Mode of Claim Payment

Name of Insured

Policy Number

Claim Number

Beneficiary Name

Mode of Payment Cheque Fund Transfer

(Please tick for mode of payment)

(All Fields are Mandatory in case of Fund Transfer)

Insured's Name as per Bank Account

Bank Account Number

Branch Name

IFSC Code

Email address

Attachments
In Support of Bank Details
(Please tick the type of proof submitted)

Cancelled Cheque Bank Passbook Copy

Declaration: I Mr./ Mrs/ Ms. _____
undersigned, legal beneficiary of the above claim, declare that all details mentioned in this form are true and I agree to the mode of payment against the particular claim number mentioned above.

Signature of Beneficiary
Stamp Required in case of Company

Date: