

Easy Health 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. 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): _____
Employee No. (for Group Policies): _____
2. Apollo DKV Card No.: _____
3. Name of the Insured (in whose name 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 Insured: _____
 - iii Date of Birth /Age: _____ DD/MM/YYYY
 - 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: _____ DD/MM/YYYY
7. Details of the doctor:
 - i Name and address of the attending medical practitioner: _____
 - ii Qualification & telephone No.: _____
8. Details of the hospital:
 - i Inpatient 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 of the hospital:

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

Details of expenses	Amount
<input type="checkbox"/> 1. 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. _____
<input type="checkbox"/> 2. Pre Hospitalization	Rs. _____
<input type="checkbox"/> 3. Post Hospitalization	Rs. _____
<input type="checkbox"/> 4. Day care Expenses	Rs. _____
<input type="checkbox"/> 5. Domiciliary Treatment	Rs. _____
<input type="checkbox"/> 6. Daily Cash for choosing shared Accommodation	Rs. _____
<input type="checkbox"/> 7. Emergency Ambulance	Rs. _____
<input type="checkbox"/> 8. Daily Cash for accompanying an insured child	Rs. _____
<input type="checkbox"/> 9. Outpatient Dental Treatment	Rs. _____
<input type="checkbox"/> 10. Spectacles, Contact Lenses, Hearing Aid	Rs. _____
<input type="checkbox"/> 11. Health Check-up	Rs. _____
<input type="checkbox"/> 12. 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, begin of coverage, sum insured).

Declaration

I hereby warrant that:

- (1) I have read and understood General Conditions of this policy, and
- (2) 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 TPA and Apollo DKV to make payment of the claim admissible as per terms, conditions and limitations of the policy to the hospital on my behalf for full and final settlement of hospital bills (in case invoices are not paid).

Place and Date: _____

Signature of the Claimant / Insured: _____

Check List of Enclosures for Submission of Claim

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

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.

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.

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.

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.

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.

Outpatient Benefit/Dental

- Duly filled and signed Claim Form
- Photocopy of ID card / Photocopy of current year policy.
- Original Medicine Bills and Original Payment Receipts.
- Original Investigation bills, original payment receipts with Reports.
- Original Consultation bills, Original payment receipts with prescription.
- Details of any Outpatient Procedures, If any
- Dental X-ray film.

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.