ApolloMunich HEALTH INSURANCE

Apollo Munich Health Insurance Co. Ltd.
10th Floor, Tower-B, Building No. 10,
DLF Cyber City, DLF City Phase -II, Gurgaon, Haryana-122002

CLAIM FORM (PERSONAL ACCIDENT)

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. We may call for additional documents if required. Use additional sheets, if required.

SECTION I: To be completed by the Policyholder / Insured Person or his representative

1. Details of the Policyholder

Policy Number (in full): _____

Employee Number (for Group Policies): _____

Name of Policyholder: _____

Address and Contact Details (Telephone/ Mobile no./E-Mail): _____

_____

_____

Date of birth (DD/MM/YYYY): _____

Occupation: _____

2. Details of Insured Person in respect of whom the claim is made

Name of Insured Person: _____

Address and Contact Details (Telephone/ Mobile no./E-Mail): _____

_____

Date of birth (DD/MM/YYYY): _____

Occupation: _____

Relationship with the Policyholder: _____

Date (DD/MM/YYYY) & time of injury/death: _____

Place/address of accident/ death: _____

Details of the accident and nature of accident (Continue on a separate sheet if necessary): _____

_____

Did the accident happen when you were working? ☐ Yes ☐ No

If yes: Name & address of employer: _____

Whether reported to Police: ☐ Yes ☐ No

If Yes: Name and address of Police Station: _____

If No, please give reasons: _____

First Information Report (FIR) Number and Date: _____

Contact details, address and telephone no. for further details: _____

_____

3. Was the Insured Person moved to hospital immediately after the accident?

☐ Yes ☐ No (If Yes, please complete the following):

Name & address of the hospital: _____

Date of admission (DD/MM/YYYY): _____

Date of discharge (DD/MM/YYYY): _____

4. Witnesses

Were there any witnesses to the event? ☐ Yes ☐ No (If yes, please complete the following)

Name: _____

Address: _____

Pincode: _____ Place of witness: _____

Phone No. (Home) : _____ (Work): _____ (Mobile): _____

Please attach all original witness statements if already obtained. In case of further witnesses please use separate sheet.

5. Do you at present have any other personal accident policy?

☐ Yes ☐ No (If Yes, please complete the following):

Name & Address of the insurer and issuing office: _____

_____

_____

Policy No.: _____

Period: _____

Sum Insured: _____

6. Tick the benefits you want to claim:

Benefit	Amount
☐ Accidental Death	
☐ Permanent Total Disablement	
Total Claimed Amount	

Please attach the following documents (please tick (✓) the appropriate box)

List – I (Accidental Death)

- ☐ Duly filled and signed Claim Form
- ☐ Policy copy
- ☐ Copy of FIR (First Information Report) /Spot Panchnama / Inquest Panchnama
- ☐ Death Certificate
- ☐ Original Death Summary
- ☐ Post Mortem Report (in case of death)
- ☐ Original Legal Heir Certificate (in case nomination has not been filed by deceased)

List – II (Permanent Total Disablement)

- ☐ Duly filled and signed Claim Form
- ☐ Policy copy
- ☐ Copy of FIR (First Information Report)
- ☐ Original treating doctor certificate describing disablement
- ☐ Original Discharge summary from the hospital
- ☐ Original photograph of the injured reflecting disablement
- ☐ Prescription and consultation papers
- ☐ Leave certificate from the employer (If Employed)
- ☐ Disability Certificate issued by Civil Surgeon or equivalent as authorised by State Government
- ☐ Medical reports, case histories, investigation reports, treatment papers as applicable.

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

7. Direct payment in your bank account (optional)

Please provide the following details of your bank account and attach a cancelled cheque pertaining to the same account.

Bank Name: _____ Bank Branch: _____

Bank Account Number: _____ IFSC Code: _____ MICR No. : _____

Note: It is agreed that the Policyholder/ Claimant will intimate in writing to Apollo Munich Health Insurance Co. Ltd. about any change in bank account details.

Declaration

I/We hereby warrant that:

(1) I have read and understood the policy terms, conditions and exclusions

(2) The foregoing particulars are true and complete in all material respects.

Place: Date:

Signature of the Insured Person:

I/We hereby warrant that:

(1) I have read and understood the policy terms, conditions and exclusions

(2) The foregoing particulars are true and complete in all material respects.

Place: Date:

Signature of the Policyholder:

SECTION II: To be completed by Nominee in the event of Policyholder's death

Name of Nominee: _____

Address and Contact Details (Telephone/ Mobile no./E-Mail): _____

_____

Date of birth (DD/MM/YYYY): _____

Relationship with the deceased: _____

Declaration to be signed by the Nominee (in the event of Insured Person's death)

I/We hereby warrant that:

(1) I have read and understood policy terms, conditions and exclusions and

(2) That the forgoing particulars are true and complete in all material respects, and

I also authorise Apollo Munich Health Insurance Company Limited to make payment of the claim admissible as per terms, conditions and limitations to the Insured Person or his legal heirs as full and final settlement. I/We will keep indemnified and hold Apollo Munich Health Insurance Company Limited harmless from any claim under this Policy by any third party.

Place: Date:

Signature of the Nominee:

SECTION III: To be completed by the Doctor who originally treated the injuries

1) Name and address of the injured person: _____

2) Gender: Male ☐ Female ☐

3) Date of birth (DD/MM/YYYY) and age: _____

4) Are you the patient's usual medical attendant? ☐ Yes ☐ No

   a) If yes, since when (DD/MM/YYYY)? _____

   b) If you have treated him/her for any previous illness or injury, please give details: _____

5) Has the patient sustained a similar injury previously or aggravated a pre-existing condition? ☐ Yes ☐ No

6) Describe nature and extent of injury: _____

a) If limb or eye is injured, please state whether right or left: _____

7) Nature and cause of accident (so far as it is known to you): _____

_____

8) Are his/her injuries

a) Solely due to the accident? ☐ Yes ☐ No

b) Traceable to any disease, infirmity, previous injuries or any other cause? ☐ Yes ☐ No

c) If Yes, please give details: _____

9) Injuries sustained in this accident are the sole cause of disablement? _____

_____

10) Date you first examined the patient for this injury (DD/MM/YYYY): _____

If admitted in Hospital:

Date of admission (DD/MM/YYYY): _____

Date of discharge (DD/MM/YYYY): _____

11) According to you, how long should the injured person be confined to bed/house as the direct and sole consequence of the injury sustained?

From (DD/MM/YYYY) : _____ To (DD/MM/YYYY) : _____

a) During this period will the injured person be able to attend to his/her normal duties?

b) If Yes, from what date (DD/MM/YYYY): _____

c) If No, please state probable date of his/her being able to attend to his/her normal duties (DD/MM/YYYY) : _____

12) Is Claimant suffering from any disease or illness apart from his injury and is there any illness by circumstances which may tend to retard recovery? ☐ Yes ☐ No

a) If Yes: Give particulars: _____

13) Present Condition: _____

14) Was he/she under the influence of intoxicants or drugs at the time of accident? _____

15) Nature of disablement: _____

a) Permanent Total Disablement ☐ Yes ☐ No

b) Permanent Partial Disablement ☐ Yes ☐ No

c) Please specify percentage: _____ %

I have personally examined the above named Insured Person. I certify that the above statements are correct and that the Insured Person is necessarily disabled by the Accident.

Place: Date:

Signature of the Doctor:

Name & Qualification: _____

Registration Number: _____

Address: _____

Stamp: