# Easy Health
## Claim Form [E-Opinion]

ApolloMunich HEALTH INSURANCE

10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

(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. Apollo Munich Member ID: _____
3. Name of the Policyholder (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 Policyholder: _____
   - iii) Date of Birth /Age: _____
   - iv) Occupation: _____
   - v) Current Residential Address & Contact Details (Telephone/Mobile No./E-Mail): _____

     _____

     _____

5. Please tick the (√) specific Critical Illness benefit for which you are claiming

| | |
|---|---|
| ☐ Cancer of specified severity | ☐ Stroke resulting in Permanent Symptoms |
| ☐ Kidney Failure requiring regular dialysis | ☐ Permanent Paralysis of Limbs |
| ☐ Multiple Sclerosis with Persisting Symptoms | ☐ Open Chest CABG |
| ☐ First Heart Attack of specified severity | ☐ Major Organ/Bone Marrow Transplant |

6. Details of clinical symptoms:

| Chief Complaints | Signs & Symptoms: | Duration |
|---|---|---|
| | | |

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

| Name | Address | Qualification | Telephone No |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Please submit copies of all consultations.

8. Details of Previous Hospitalizations (If any)

| Date of Admission | Date of Discharge | Diagnosis and Treatment | Name & Address of the Hospital |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please submit copies of all discharge summaries.

9. Details of Investigations done

   Investigation Reports of the last one Year attached Yes ☐ / No ☐

10. Is the patient suffering from any of the following?
    - i) Hypertension: Yes ☐ / No ☐ If Yes, Since when _____
    - ii) Diabetes: Yes ☐ / No ☐ If Yes, Since when _____
    - iii) Heart Disease: Yes ☐ / No ☐ If Yes, Since when _____
    - iv) Any other chronic ailment: Yes ☐ / No ☐

    If Yes, (Please specify): _____ Since when _____

11. Personal History
    - i) Alcoholism: Yes ☐ / No ☐
    - ii) Smoking: Yes ☐ / No ☐
    - iii) Tobacco chewing: Yes ☐ / No ☐

12. No. of Documents submitted including this CLAIM FORM: _____
13. Current Clinical Diagnosis: _____

    _____

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14. Treatment and Medication Details (Name /Dosage & Frequency): _____

15. E-Opinion Requested For: _____

Doctor's Opinion (Attach further sheet if space is insufficient): _____

Date: _____ Name of the Consultant: _____

Seal: _____ Signature of the Doctor: _____

**Disclaimer:**

Each Insured Person expressly notes and agrees that:

1. It is entirely for the Insured Person to decide whether to obtain an E-opinion, from which Medical Practitioner from Our Panel to take the E-opinion and the use (if any) to which the E-opinion so obtained is put.
2. We do not provide an E-opinion or make any representation as to the adequacy or accuracy of the same, the Insured Person's or any other person's reliance on the same, or the use to which the E-opinion is put.
3. We assume no responsibility for and will not be responsible for any actual or alleged errors, omissions or representations made by any medical practitioner or in any E-opinion or for any consequences of any action taken or not taken in reliance thereon.

AMHI/PR/H/0018/0044/102010/P