Group Health Shield Cancer Care/Critical Illness/Cardiac Care Claim Form

This form is to be filled by the Claimant in block letters. The issue of this form is not to be taken as an admission of liability. Primarily, the Policyholder will be the Claimant. In case of the death of the Policyholder, the Nominee will be the Claimant. If the Nominee is a minor, the Appointee will be the Claimant.

HDFC Life
Sar utha ke jiyo!

(A) DETAILS OF PRIMARY INSURED/CLAIMANT:

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

c. Company/TPA ID No.:

d. Name: SURNAME FIRST NAME MIDDLE NAME

e. Address:

City: State:

Pin Code: Phone No.: Email ID.:

f. Loan Account Number/Member ID:

(B) DETAILS OF INSURANCE HISTORY OF INSURED PERSON (If the space provided is inadequate, please attach/enclose annexures):

a. Currently covered by any other Mediclaim/ Health/Critical Illness/Cancer Insurance: ☐ Yes ☐ No b. Date of commencement of first insurance without break: D D M M Y Y

c. If yes, company name: Policy No.:

Sum Insured (INR):

d. Have you been hospitalised in the last four years since inception of the contract? ☐ Yes ☐ No Date: D D M M Y Y

Diagnosis:_____ Claim Status:

e. Previously covered by any other Mediclaim/Health/ Critical Illness/Cancer Insurance ☐ Yes ☐ No f. If yes, company name:

Policy No.: Sum Insured (INR):

Benefit Type: ☐ Mediclaim ☐ Critical Illness ☐ Cancer Insurance Date of commencement of first insurance without break: D D M M Y Y

Claim Status: ☐ Approved ☐ Rejected ☐ Pending

Other insurance policy details or information which will enable us to process the claim: _____

_____

_____

_____

(C) DETAILS OF INSURED PERSON HOSPITALISED:

a. Name: SURNAME FIRST NAME MIDDLE NAME

b. Gender: Male ☐ Female ☐ c. Age (years): Y Y M M d. Date of Birth: D D M M Y Y

e. Relationship with Primary Insured/Claimant: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ (Please Specify):

f. Occupation: Service ☐ Self-Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ (Please Specify):

fi. Nature of Work:

fii. Employer Name:

fiii. Employer Address:

fiv. Employer Contact Details: Phone No.: Email ID: _____

Mobile No.:

g. Residential address (if different from above):

City: State:

Pin Code: Phone No.: Email ID: _____

(D) DETAILS OF HOSPITALISATION/DIAGNOSIS:

a. Name of hospital where admitted/diagnosed:

b. Room category occupied: Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐

c. Hospitalisation due to: Injury ☐ Illness ☐ Maternity ☐ d. Date of injury/Date when disease first detected/Date of delivery D D M M Y Y

e. Date of Admission: D D M M Y Y **f.** Time: H H : M M **g.** Date of discharge: D D M M Y Y **h.** Time: H H : M M

i. If injury, give cause: Self-inflicted ☐ Road Traffic Accident ☐ Substance Abuse / Alcohol Consumption ☐

i) If Medico-legal: ☐ Yes ☐ No ii) Reported to police: ☐ Yes ☐ No iii) MLC Report & Police FIR attached: ☐ Yes ☐ No

j. System of Medicine: ____________________ **k.** Type of Cancer: Carcinoma in situ ☐ Early Stage Cancer ☐ Major Cancer ☐

(E) DETAILS OF CLAIM:

a. Details of the treatment expenses claimed:

i. Pre-Hospitalisation Expense: INR

ii. Hospitalisation Expenses: INR

iii. Post-Hospitalisation Expenses INR

iv. Health-Check up Cost: INR

v. Ambulance Charges: INR

vi. Others (code): INR

Total INR

vii. Pre-Hospitalisation Period: Days

viii. Pre-Hospitalisation Period: Days

b. Claim for domiciliary hospitalisation: ☐ Yes ☐ No (If yes, provide details in annexure)

c. Details of lump sum/cash benefit claimed:

i. Hospital Daily Cash: INR

ii. Surgical Cash: INR

iiii. Critical Illness Benefit: INR

iv. Convalescence: INR

v. Pre/Post Hospitalisation: INR

vi. Others (code): INR

vii. Lump sum benefit: INR

Total INR

viii. Cancer Care Benefit: INR

d. Claim Documents Submitted - Check List:

- ☐ Claim Form Duly Signed
- ☐ Operation Theatre Notes
- ☐ Copy of the Claim Intimation, if any
- ☐ Hospital Discharge Summary: Present/Past hospitalisation
- ☐ First Consultation and all Follow- up Consultation Notes
- ☐ Hospital Main Bill
- ☐ Investigation Reports/Plates (Xray/CT/MRI/ USG/HPE)
- ☐ Employer Certificate: Leave Records, Sick-leave Certificate
- ☐ Hospital Break-up Bill
- ☐ Laboratory Test Reports
- ☐ Attested True Copy of Indoor Case Papers of the Hospital(s)
- ☐ Hospital Bill Payment Receipt
- ☐ Endoscopy/Colonoscopy Report
- ☐ Attending Physician's Statement
- ☐ Pharmacy Bill
- ☐ PAP Smear
- ☐ Attested Copy of Cancelled Personalised Cheque
- ☐ ECG
- ☐ Mammography
- ☐ Latest Bank Statement (not more than 3 months old)
- ☐ Doctor's Prescriptions
- ☐ Blood Test for Cancer Diagnosis (Tumor Marker)
- ☐ Copy of Pass Book (indicating account holder' name, account number & IFSC)
- ☐ Others
- ☐ Clinical/Hospital Reports
- ☐ Doctor Consultation Referral Letter
- ☐ Any Other Investigation Report
- ☐ Doctor's Request for Investigation

(F) CLAIMED CONDITION DETAILS:

a. Final Diagnosis: **b.** Date of Diagnosis: D D M M Y Y

c. Date of First Consultation with Doctor: D D M M Y Y **d.** Nature and Duration of Complaints Necessitating Medical Attention:

e. Date when These Complaints First Became Evident: D D M M Y Y

f. Site of Tumour:

(G) PAST HEALTH HISTORY OF LIFE ASSURED:

a. Any Other Illness/Surgery Prior to the Current Illness (If the space provided is inadequate, kindly attach annexures): ____________________

____________________ **b.** Date when this Illness was First Detected: D D M M Y Y

c. Any Previous Malignancy or Pre-Malignancy Condition(s): ☐ Yes ☐ No

d. If Yes, Please Provide Details: ____________________

____

(H) DETAILS OF THE LIFE ASSURED'S HABITS:

a. Substance	b. Forms of Consumption	c. Quantity	d. Duration
Alcohol	☐ Beer ☐ Wine ☐ Whiskey ☐ Others Please Specify	Per Day ____________ ml ☐ Bottle ☐	
Tobacco	☐ Cigarettes ☐ Beedis ☐ Chewing Tobacco	Per Day_____No. of Sticks ☐ Packets ☐	
e. Others, please specify:			

Were you required to be away from work due to this condition/these habits? ☐ Yes ☐ No

If yes, please provide details of time away from work (dates, duration):____

(I) HOSPITALISATION AND CONSULTATION DETAILS: (If the space provided is inadequate, please attach/enclose annexures).

Sr. No	Name of the Hospital/Doctor	Contact Details of Hospital/Doctor	Dates of Consultation/Admission & Discharge	Diagnosis
1				
2				
3				
4				
5				

(J) DETAILS OF BILLS ENCLOSED

SL. No.	Bill No.	Date	Issued by	Towards	Amount (INR)
1		D D M M Y Y		Hospital Main Bill	
2		D D M M Y Y		Pre-hospitalisation Bill:	
3		D D M M Y Y		Post-hospitalisation Bill:	
4		D D M M Y Y		Pharmacy Bills	
5		D D M M Y Y			
6		D D M M Y Y			
7		D D M M Y Y			
8		D D M M Y Y			
9		D D M M Y Y			
10		D D M M Y Y			

(K) DETAILS OF PRIMARY INSURED'S/CLAIMANT'S BANK ACCOUNT

a. PAN: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **b.** Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c. Bank Name and Branch:

d. Cheque/DD Payable Details: ______________________________________ **e.** IFSC: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

f. Attested Photocopy Attached for: ☐ Cancelled Personalised Cheque ☐ Latest Bank Statement (not more than 3 months old)
☐ Copy of Pass Book (indicating Account Number & IFSC)

(L) DECLARATION BY THE INSURED/CLAIMANT:

I/We hereby declare that the information furnished in this claim is true and correct to the best of my/our knowledge and belief. If I/we 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/our right to claim Cancer Care benefit shall be forfeited. I/We also agree and authorise TPA/Insurance company, to seek necessary medical information/documents from any hospital/medical practitioner who has attended to the person against whom this claim is made. I/We hereby declare that I/we have included all the bills/receipts for the purpose of this claim and that I/we will not be making any supplementary claim.

I/We, the Life Assured, acknowledge and declare receipt of the entire amount due and payable under the policy mentioned above towards full and final settlement of the claim. I/We declare that HDFC Life Insurance Company Limited (HDFC Life) is discharged of all the liabilities under the said policy.

Date: D D M M Y Y Place:_______________________________ Signature of the Insured/Claimant: Re. 1/- Revenue Stamp

Please sign across the revenue stamp

(M) AUTHORISATION BY THE INSURED/CLAIMANT:

I/We,_____, hereby authorise - (i) the hospital(s)/doctor(s) who have examined or treated me/the Life Assured for any ailment/illness (ii) any laboratory where I/the Life Assured may have undergone any investigation or tests (iii) other insurance companies to furnish details of my/our insurance policies with them (iv) employer(s), including any previous employer to provide information regarding the leave and medical assistance availed by me whether before or after the date mentioned in the reply to question no. (V) to furnish details of such ailments/illness and examination, treatment, investigation or test to HDFC Life or such persons or agency as may be authorised by the said Company. I/We further authorise any government agencies including police and revenue to provide information and records that may be needed by HDFC Life to process the claim. I/We agree to provide and furnish any other information/reports, if required by HDFC Life for processing the claim. In addition to postal or courier service, the Company may, at its discretion, use any electronic media/registered email ID for communicating with me/us.

Date: D D M M Y Y Place: _____ Signature of the Insured/Claimant:

Name of the Life Assured/Claimant: SURNAME FIRST NAME MIDDLE NAME

Relationship with the Life Assured (if the Claimant is other than the Life Assured):

(N) WITNESS ATTESTATION/DECLARATION:

Name of the Witness: SURNAME FIRST NAME MIDDLE NAME

Address:

City: State:

Pin Code: Contact No.: Email ID:_____

Date: D D M M Y Y Place:_____ Signature of the Witness:

The Witness should be either an Advocate, Bank Manager, Block Development Officer, Commissioner of Oaths/Notary, Doctor, Gazetted Officer, Head Master of a High School, Head Post Master or Departmental Sub-Post Master, Magistrate or President of a Village or Local Body.

If the Life Assured/Claimant signs in vernacular or affixes thumb impression, the witness should also sign the following declaration

Certified that the contents of this form were explained to the Life Insured/Claimant in_____language and he/she has affixed his/her signature or thumb impression after fully understanding the same.

Date: D D M M Y Y Place:_____ Signature of the Policyholder/Claimant:

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled by the Insured/Claimant)

DATA ELEMENT	DESCRIPTION	FORMAT
	SECTION A- DETAILS OF PRIMARY INSURED	
a. Policy No.	Enter the Policy number	As allotted by the insurance company
b. Sl. No./Certificate No.	Enter the social insurance number or certificate number of the social health **insurance scheme**	As allotted by the organisation
c.Company TPA ID No.	Enter the TPA ID No.	Licence number as allotted by IRDAI 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 if covered by other 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 organisation 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 hospitalised in the last four years since inception of the contract?	Indicate whether hospitalised in the last four years	Tick Yes or No
Date	Enter the date of hospitalisation	Use dd-mm-yy format

(GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled by the Insured/Claimant)

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION B - DETAILS OF INSURANCE HISTORY		
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 organisation 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 INR
Benefit Type	Enter the benefits covered as per the Policy	Tick the relevant
Date of commencement of first insurance without break	Enter the date of first insurance cover commencement	Use dd-mm-yy format
Claim status	Indicate the status of claims made under the Policy	Tick the relevant
Any other information	Enter any other previous insurance details	Open Text
SECTION C - DETAILS OF INSURED PERSON HOSPITALISED		
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 with primary Insured	Indicate relationship of patient with Policyholder	Tick the right option. If others, please specify
f. Occupation	Indicate occupation of patient	Tick the right option. If others, please specify
Nature of Work	Indicate the nature of occupational duty	Open Text
Employer Name	Enter the employer name	Open Text
Employer Address	Enter employer address	Include street, City and Pin Code
Employer Contact Details	Enter employer contact details	Complete contact details
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 email address
SECTION D - DETAILS OF HOSPITALISATION		
a. Name of Hospital where Insured	Enter the name of hospital	Name of hospital in full
b. Room category occupied	Indicate the room category occupied	Tick the right option
c. Hospitalisation due to	Indicate reason of hospitalisation	Tick the right option
d. Date of Injury/Date when disease first detected / Date of delivery	Enter the relevant date	Use dd-mm-yy format
e. Date of admission	Enter date of admission	Use dd-mm-yy format
f. Time	Enter time of admission	Use hh:mm format
g. Date of discharge	Enter date of discharge	Use dd-mm-yy format
h. Time	Enter time of discharge	Use hh:mm format
i. If injury, give cause	Indicate cause of injury	Tick the right option
If Medico-legal	Indicate whether injury in medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled by the Insured/Claimant)

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION D - DETAILS OF HOSPITALISATION		
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j. System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
k. Type of Cancer	Indicate type of cancer	Tick the right option
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 Hospitalisation	Indicate whether claim is for domiciliary hospitalisation	Tick Yes or No
c. Details of lump sum/cash benefit claimed	Enter the amount claimed as lump sum /cash benefit	In INR (Do not enter paise values)
d. Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
SECTION F - CLAIMED CONDITION DETAILS		
a. Final Diagnosis	Indicate reason of hospitalisation	Open Text
b. Date of Diagnosis	Enter the date diagnosis	Use dd-mm-yy format
c. Date of First Doctor Consultation	Enter the date on which a doctor was first consulted	Use dd-mm-yy format
d. Nature and Duration of Complaints Necessitating Medical Attention:	Describe the complaints in detail along with duration of each	Open Text
e. Date when These Complaints First Became Evident:	Enter date on which the complaints were first noticed	Use dd-mm-yy format
f. Site of Tumour	Indicate the location of the cancerous tumour	Open Text
SECTION G - PAST HEALTH HISTORY OF LIFE ASSURED		
a. Any Other Illness/Surgery Prior to the Current Illness	Indicate the previous medical/surgical history of Life Assured	Open Text
b. Date when this Illness was First Detected	Enter the date on which the previous illness or disease was detected	Use dd-mm-yy format
c. Any Previous Malignancy or Pre-Malignancy Conditions	Indicate whether there is a previous history of malignancy or pre-malignancy	Tick Yes or No
d. If Yes, Please Provide Details	Describe the previous history of malignancy or pre-malignancy	Open Text
SECTION H - DETAILS OF THE LIFE ASSURED'S HABITS		
Indicate the Life Insured's Habits		
SECTION I - HOSPITALISATION AND CONSULTATION DETAILS		
Indicate the Life Insured's past and current hospitalisation and doctor consultation details		
SECTION J - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amounts in INR		
SECTION K - 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 bank name along with the branch	Name of the bank in full
d. Cheque/DD payable details	Enter the name of the beneficiary in whose favour the cheque/DD will be issued	Name of the individual/organisation in full

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled by the Insured/Claimant)

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION K - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
e.IFSC	Enter the IFSC of the bank branch	IFSC of the bank branch in full
SECTION L - DECLARATION BY THE INSURED/CLAIMANT		
Read the declaration carefully and mention the date (in dd:mm:yy format), place (open text), fix Re 1 revenue stamp and sign.		
Read the authorisation carefully and mention the date (in dd:mm:yy format), place (open text), relationship with the Life Assured and sign.		
Read authorisation carefully and mention the date (in dd:mm format), place (open text), relation to Life Assured and sign.		

Customer Acknowledgement Copy (Group Health Shield Cancer Care/Critical Illness/Cardiac Care Claim Form)

Policy No.: _____ Policyholder's Name: _____

HDFC Life Stamp

Branch: _____ Date: DD/MM/YYYY _____ Time: _____

View Premium Calendar, Pay Premium Online, Track Fluctuations in the Fund Value, Print your Annual Premium Statement, Fund Switch, Revive your Policy & lots more! Visit www.hdfclife.com & register for My Account today!

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Regd. Off: 13th Floor, Lodha Excelus, Apollo Mills Compound, NM. Joshi Marg, Mahalaxmi, Mumbai-400011.
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