

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT

PART A

TO BE FILLED IN BY THE INSURED

This issue of this Form is not to be taken as an admission of liability



Sar aartha ke jiyo!

DETAILS OF PRIMARY INSURED:

(To be filled in block letters)

Form fields for Primary Insured details including Policy No., Company/TPA ID No., Name, Address, City, State, Pin Code, Phone No., and Email ID.

DETAILS OF INSURANCE HISTORY:

Form fields for Insurance History including current coverage status, date of commencement, company name, sum insured, hospitalization history, and previous coverage.

DETAILS OF INSURED PERSON HOSPITALIZED:

Form fields for Insured Person Hospitalized details including Name, Gender, Age, Date of Birth, Relationship to Primary Insured, Occupation, and Address.

DETAILS OF HOSPITALIZATION:

Form fields for Hospitalization details including Name of Hospital, Room Category, Date of Admission, Date of Discharge, and System of Medicine.

DETAILS OF CLAIM

Form fields for Claim details including treatment expenses, hospitalization expenses, ambulance charges, and a checklist of submitted claim documents.

DETAILS OF BILLS ENCLOSED:

Table with columns: SL. No., Bill No., Date, Issued by, Towards, and Amount (Rs).

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

Form fields for Primary Insured's Bank Account details including PAN, Account Number, Bank Name and Branch, and IFSC Code.

(IMPORTANT: PLEASE TURN OVER)

Note: As per IRDA circular dated February 13, 2014, all payouts to policyholders are to be made via the electronic mode [NEFT] only.

SECTION A

SECTION B

SECTION C

SECTION D

SECTION E

SECTION F

SECTION G

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in this claim is true & correct to the best of my knowledge and belief. If I 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 right to claim reimbursement shall be forfeited. I also consent & authorise TPA/Insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that will not be making any supplementary claim except the pre/post-hospitalization claim, if any. 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: Place _____Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)

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 of the certificate number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No.	License number as allotted by IRDA 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 whether currently covered by another 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 organization 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 Hospitalized in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of hospitalization	User mm-yy format
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 organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
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 to 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
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 e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
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) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of Injury / Date 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
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
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 Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/cash benefit claimed	Enter the amount claimed as lump sum /cash benefit	In rupees (Do not enter paise values)
d) Claim Documents Submitted -Check List	Indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amounts in rupees		
SECTION G - 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 beneficiary the cheque/DD should be made out to	Name of the individual/organization in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

NOTE

With reference to recent regulatory changes, please submit PAN or Form 60 (if you do not have a PAN) with HDFC Life with immediate effect. Pls update via My Account/ service@hdfclife.com/022-68446530/HDFC Life branch. Ignore if submitted.

HDFC Life Insurance Company Limited (HDFC Life). CIN: L65110MH2000PLC128245. IRDAI Registration No. 101.

Regd. Off: 13th Floor, Lodha Excelus, Apollo Mills Compound, N.M. Joshi Marg, Mahalaxmi, Mumbai - 400 011.

Call **022-68446530** (Call charges apply). Available Mon-Sat from 10 am to 7 pm.

DO NOT prefix any country code e.g. +91 or 00 | Email – service@hdfclife.com | nriservice@hdfclife.com (For NRI customers only) Visit – www.hdfclife.com.