

SURGICARE CLAIM FORM

(Issuance of this form does not imply acceptance of liability)

Policy Details:

Policy Number: _____ Plan: _____
Policy start date: MM/DD/YYYY Policy end date: MM/DD/YYYY TPA ID NO: _____
Name of Life Assured: _____

Claimant Details:

Name: _____
Relation to Life Assured DOB: MM/DD/YYYY Gender: Male/Female
Communication Address: _____
City/District: _____ State: _____ Pin Code: □□□□□□
Tel No: □□ □□ □□□□□□□□ Mobile No: □□ □□□□□□□□□□
Email Address: _____

Claim Details:

Surgical Hospitalisation Days Non ICU Hospitalisation Days ICU

Hospitalisation details:

Date of Admission: MM/DD/YYYY Time of Admission: 00 Hrs: 00 Min AM/PM
Date of Discharge: MM/DD/YYYY Time of Discharge: 00 Hrs: 00 Min AM/PM
Final Diagnosis: _____
Hospital Name: _____
Hospital Registration No: _____
Address of Hospital: _____
City/District: _____ State: _____
Pin Code: □□□□□□ Tel No: □□ □□ □□□□□□□□
Name of Treating Doctor: _____
Qualification & Registration No: _____ Date of first consultation: MM/DD/YYYY
Address: _____
Tel No: □□ □□ □□□□□□□□ Mobile No: □□ □□□□□□□□□□
Signature of the treating doctor: _____ Date: MM/DD/YYYY

HDFC STANDARD LIFE INSURANCE COMPANY LIMITED

Correspondence Address: 11th Floor, Lodha Excelus, Apollo Mills Compound, N.M.Joshi Road, Mahalaxmi, Maharashtra,
Mumbai - 400 011, Phone:022-6668 2666
Regd. Office: Ramon House, H.T. Parekh Marg, 169, Backbay Reclamation, Churchgate, Mumbai 400 020, INDIA

Inpatient stay details: (If space provided is inadequate, kindly attach annexures)				
Non ICU Stay:				
Sr No	Date of Admission	Time of Admission	Date of Discharge/Transfer	Time of Discharge/Transfer
	MM/DD/YYYY	00 Hrs: 00 Min AM/PM	MM/DD/YYYY	00 Hrs: 00 Min AM/PM
ICU Stay:				
Sr No	Date of Admission	Time of Admission	Date of Discharge/Transfer	Time of Discharge/Transfer
	MM/DD/YYYY	00 Hrs: 00 Min AM/PM	MM/DD/YYYY	00 Hrs: 00 Min AM/PM

Illness Details: (If space provided is inadequate, kindly attach annexures)	
Name of Surgery performed/ Final Diagnosis/ Reason for Claim	
Describe in brief the nature of illness	
What were the symptoms necessitating medical attention	
Please mention the date on which this symptoms became first evident	
Describe in brief the treatment received for the illness	
Please mention any other illness/surgery you suffered from prior to the current illness	

Consent by Claimant:	
<p>I hereby authorize any medical attendant/ doctor/ employer/ business associate of the Life Assured/ or any other person who has coordinated with the above named Life Assured to provide any information or details as to the state of health and habits of the Life Assured, to the Company, within his knowledge before or after this policy was issued.</p>	
Signature/Thumb impression of the Life Assured/Claimant:	Date: MM/DD/YYYY Location:
Name of the Life Assured/Claimant:	
Relationship with the Life Assured (if the claimant is other than the Life Assured):	
Name of Witness:	Signature of Witness:
<p>The witness to be either an Advocate, Bank Manager, Block Development Officer, Commissioner of Oaths/Notary, Doctor, Gazette Officer, Head Master of a High School, Head Post Master or Departmental Sub-Post Master, Magistrate or President of a Village or Local Body.</p>	

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Bank Details of the Claimant:Bank Account No:

Branch Name:

Bank Name:

Name of Account Holder:

I hereby declare that the particulars given are correct and complete. If transaction is delayed or not effected at all for reasons of incomplete form or information, I shall not hold HDFC Standard Life Insurance Co. Ltd responsible. I agree to discharge the responsibility expected of me as a participant under the scheme.

In case of non credit to my bank account with/without assigning any reasons thereof or if the transaction is delayed or not effected at all for reasons of incomplete/incorrect information. I would not hold HDFC Standard Life Insurance Co. Ltd responsible.

Life Assured/Claimants Signature:

Date: MM/DD/YYYY

Location:

Authorization: (To be signed by the Claimant)

To,

I, Mr. / Ms. _____ (name), _____ (relation) of Mr. / Ms. _____ (name of the Life Assured) hereby give my consent to M/s HDFC Standard Life Insurance Co. Ltd., and / or its representative to obtain (including photocopies) all the employment / medical / hospital records / other records / information pertaining to the treatment of (Life Assured) Mr. / Ms. _____.

Yours faithfully,

Signature of the Life Assured/Claimant:

Name of the Life Assured/Claimant:

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

Policy No:

Date: MM/DD/YYYY

Disclaimer: (To be signed by the Claimant)

I hereby declare that the above information is true & correct to the best of my knowledge and belief. If I have made any false, fraud or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses be forfeited.

I hereby declare that I have included all bills / receipts for the purpose of this claim and I will not be making any supplementary claim with the company in respect thereof.

Signature of the Life Assured/Claimant:

Name of the Life Assured/Claimant:

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

Policy No:

Date: MM/DD/YYYY

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Documents Enclosed Checklist:

A) Claim Documents (to be duly verified by the Policyholder or claimant)

- Claim form in original duly filled and signed
- Copy of the policy document, page 1 to page 4

B) Other Documents/supportings (Duly verified by Hospital Authorities)

- Copy of any one of the following photo identity document; PAN card/Valid Passport/ Valid Driving license/Election ID card/Central Government Health Card/Employee State Insurance Scheme card
- Copy of the hospitalization discharge card/summary
- Hospital invoice(s)(summary and the itemized invoices) and corresponding payment receipts
- Surgical summary (in case the claimant has undergone a surgery) verified by the operating surgeon
- Copies of all the supporting diagnostic reports and prescriptions
- Copies of all Pharmacy receipts and corresponding prescriptions
- Copy of the TPA ID card

Any other documents or information:

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