IndusInd GENERAL INSURANCE
FORMERLY RELIANCE GENERAL INSURANCE

Claim No.: _____

HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A - CLAIM FORM

TO BE FILLED IN BY THE INSURED (To be filled in BLOCK LETTERS)

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

SECTION A - DETAILS OF PRIMARY INSURED			
a) Type of claim	☐ Hospitalization ☐ Pre Hospitalization ☐ Post Hospitalization ☐ Health check-up ☐ OPD		
b) Pre authorization obtained	☐ Yes ☐ No	Period To	☐ Individual ☐ Group
c) Policy type	☐ Individual ☐ Group		
d) Group/Company name			
e) Policy No		f) Sl. No/Certificate No	
g) Company/TPA ID No.		h) Name	
I) Address			
City		State	
Pincode		Phone No	
E-mail Id			
j) PAN No.			
k) Monthly Income	☐ Upto ₹ 20,000 ☐ ₹ 20,001 to ₹ 50,000 ☐ ₹ 50,001 to ₹ 1,00,000 ☐ ₹ 1,00,001 and above		

SECTION B - DETAILS OF INSURANCE HISTORY			
a) Currently covered by any other Mediclaim/Health Insurance			☐ Yes ☐ No
b) Date of commencement of first insurance without break			D D / M M / Y Y Y Y
c) If yes, Company Name			
Policy No		Sum Insured ₹	
d) Have you been hospitalized in the last four years since inception of the contact?			☐ Yes ☐ No
Date	D D / M M / Y Y Y Y	Diagnosis	
e) Previously covered by any other Mediclaim/Health Insurance			☐ Yes ☐ No
f) If yes, Company Name			

SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED			
a) Name			
b) Gender	☐ Male ☐ Female	c) Age	_____ Years _____ Months
d) Date of Birth	D D / M M / Y Y Y Y		

e) Relationship to Primary insured	☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other - Please Specify _____		
f) Occupation	☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other - Please Specify _____		
g) Address (if different from above)			
City		State	
Pin Code		Phone No	
Email Id			

SECTION D - DETAILS OF HOSPITALIZATION			
a) Name of Hospital where admitted			
b) Room Category occupied	☐ Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room		
c) Hospitalization due to	☐ Injury ☐ Illness ☐ Maternity		
d) Date of Injury/Date disease first detected /Date of delivery		D D / M M / Y Y Y Y	
e) Date of Admission	D D / M M / Y Y Y Y	f) Time	H H / M M AM/PM
g) Date of Discharge	D D / M M / Y Y Y Y	h) Time	H H / M M AM/PM
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			

SECTION E - DETAILS OF CLAIM			
a) Details of treatment expenses claimed			
i. Pre hospitalization expenses	₹	ii. Hospitalization expenses	₹
iii. Post hospitalization expenses	₹	iv. Health check up cost	₹
v. Ambulance charges	₹	vi. Others (code)	₹
TOTAL	₹		
vii. Pre hospitalization period	_____ Days	viii. Post hospitalization period	_____ Days
b) Claim for Domiciliary Hospitalization ☐ Yes ☐ No (if yes provide details in annexure)			
c) Details of Lump sum/cash benefit claimed			
i. Hospital Daily Cash	₹	ii. Surgical cash	₹
iii. Critical illness benefit	₹	iv. Convalescence	₹

IRDAI Registration No. 103 IndusInd General Insurance Company Limited (Formerly known as Reliance General Insurance). An ISO 9001:2015 Certified Company For complete details on the benefits, coverage, terms & conditions and exclusions, do read the sales brochure, prospectus and policy wordings carefully before concluding sale. Registered & Corporate Office: 6th Floor, Oberoi Commerz, International Business Park, Oberoi Garden City, Off. Western Express Highway, Goregaon (E), Mumbai-400063. Corporate Identity Number: U66603MH2000PLC128300. Health Insurance Policies Other Than Travel And Personal Accident - Part - A. UIN No.: XXXXXXXXXXXXXXXXXXXX.
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v. Pre/Post hospitalization Lump sum benefit	₹	vi. Others	₹
TOTAL	₹		

SECTION F - DETAILS OF BILLS ENCLOSED

S. No.	Bill No	Date	Issued By	Towards	Amount ₹
1		D D / M M / Y Y Y Y		Hospital main Bill	
2		D D / M M / Y Y Y Y		Pre hospitalization Bills _____Nos	
3		D D / M M / Y Y Y Y		Post hospitalization Bills _____Nos	
4		D D / M M / Y Y Y Y		Home care treatment Bills	
5		D D / M M / Y Y Y Y		Pharmacy Bills	
6		D D / M M / Y Y Y Y		Other expenses if any _____	
7		D D / M M / Y Y Y Y			
8		D D / M M / Y Y Y Y			
9		D D / M M / Y Y Y Y			
10		D D / M M / Y Y Y Y			

CLAIM DOCUMENTS SUBMITTED CHECK LIST

S. No.	Documents
1	☐ Claim form duly signed
2	☐ Copy of the claim intimation, if any
3	☐ Hospital main bill
4	☐ Hospital break up bill
5	☐ Hospital bill payment receipt
6	☐ Hospital discharge summary
7	☐ Pharmacy bill
8	☐ Operation theatre notes
9	☐ ECG
10	☐ Doctor's request for investigation
11	☐ Investigation reports (including CT/MRI/USG/HPE)
12	☐ Doctor's prescriptions
13	☐ Others

As per policy terms & conditions, the Company reserves its right to have the Insured examined by a Doctor appointed by it for verification of diagnosis.

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SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

1. Name of the Bank Account Holder	☐ Mr. ☐ Mrs. ☐ Ms. F I R S T M I D D L E L A S T		
2. Bank Account No.:		3. Account:	☐ Saving ☐ Current ☐ Other
4. Name of the Bank			
5. Branch			
6. MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)			
7. IFSC Code (11 character code appearing on your cheque leaf)			

☐ I understand that any refund due on the premium payment / any payment / claims to be directly credited to my aforesaid Bank Account.*

*As per IRDAI, its mandatory that all payments made to the insured are only through electronic mode.

PEP DECLARATION:

Are you a Politically Exposed Person (PEP)?	☐ Yes ☐ No
If yes, please mention the position held	
Is any of your close relation or family member a PEP?	☐ Yes ☐ No
If yes, please mention the name and relation and the position held by such close relative/family member.	

I hereby declare that in future if me, any of my close relatives or any of my family member attains a position of PEP then I shall confirm the same to IndusInd General Insurance Co. Ltd as a mandate. I understand that this is a crucial information under the PMLA Rules and AML/CFT Guidelines and shall confirm that the answers given by me is true. In case the company comes to know that this is a misrepresentation and concealment of information then the policy shall be put on hold for scrutiny by the company and I shall be solely responsible for the same.

Note :

"**Politically Exposed Persons" (PEPs)** shall have the meaning assigned to it under sub clause (db) of clause (1) of Rule 2 of the Prevention of Money Laundering (Maintenance of Records) Rules, 2005."

(db) "Politically Exposed Persons" (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials".

AML Guidelines

1. I/We hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been /will be paid out of proceeds of crime related to any of the offense listed in Prevention of Money Laundering Act,2002.
2. I Understand that the Company has the right to call for document to established sources of funds.
3. The Insurance Company has right to cancel the insurance contract in case I am/have been found guilty by competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

Place: _____

Date: _____

_____

Signature of Proposer

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GENERAL DECLARATION:

I understand that as per the new AML/CFT Guidelines issued IndusInd General Insurance Co. Ltd will be verifying my details pertaining to KYC and PAN provided at the time of proposal.

I further, do hereby agree and consent that in the case of the event of a mismatch of information provided by me in the proposal form, identification proof, and address proof at the time of issuance of the policy. I request IndusInd General Insurance Company Limited to issue the policy with the details appearing as per my proposal form. I will be solely responsible for any consequences arising out of the difference in detail given by me during the verification of supporting documents provided by me at the time of issuance of the policy or otherwise.

SECTION H - DECLARATION BY THE INSURED

I hereby declare that the information furnished in this claim form is true and correct to the best of my knowledge and belief. If I made any false or untrue statement, suppression or concealment of any material fact with respects to questions asked in relation to the claimed, my right to claim reimbursement shall be forfeited. I also consent & authorize 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 I will not be making any supplementary claim except the pre/post hospitalization claim, if any.

Date: _____ _____

Place: _____ Signature of the Insured

HEALTH CARE ADDRESS:

Health Care Unit: IndusInd General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad - 500081. **Email: healthcare@indusindinsurance.com.**

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