To ensure priority processing, please complete all sections in CAPITAL letters. Please tick ☑ in the relevant boxes.

CLAIM FORM FOR HEALTH INSURANCE POLICIES

OTHER THAN TRAVEL AND PERSONAL ACCIDENT

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

(Guidance for filling claim form - **Part A** is available on our website: www.royalsundaram.in)

Royal Sundaram
General Insurance

Please note that accepting claim intimation does not indicate claim admissibility. Claim will be processed as per policy terms and conditions. Also, please note that claims arising from "Excluded hospitals" will not be approved, as per policy terms and conditions. Please refer our website www.royalsundaram.in for list of Excluded hospitals.

PART A

DETAILS OF PRIMARY INSURED (PROPOSER) — **(TO BE FILLED IN BY THE INSURED)**

SECTION A

a) Policy No. | b) Sl. No./ Certificate No.

c) Membership No./ TPA ID No.

d) Name

e) Address

City | State

Pin Code | Land Line (with STD Code)

MOST IMPORTANT

Mobile No. | WhatsApp No. | Claims status will be shared on WhatsApp no wherever possible

PLEASE PROVIDE ACTIVE EMAIL ID ONLY AS CLAIMS CORRESPONDENCE WILL BE DONE TO THIS EMAIL ID.

Email ID

Alternate Email ID

DETAILS OF INSURANCE HISTORY (MANDATORY)

SECTION B

a) Currently covered by any other Mediclaim/Health Insurance ☐ Yes ☐ No

b) If yes, Company Name

Policy No. | c) Date of commencement of first Insurance without break (D D M M Y Y Y Y)

d) Sum Insured (Rs.) | e) Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No f) Date (D D M M Y Y Y Y)

g) Diagnosis

DETAILS OF INSURED PERSON HOSPITALIZED

SECTION C

a) Name

b) Gender ☐ Male ☐ Female | c) Age (Y Y Years) (M M 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) Communication Address

City | State

Pin Code | Land Line (with STD Code)

g) Occupation ☐ Doctor ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please Specify) _____

h) Name of the Employer

i) Address of the Employer

DETAILS OF HOSPITALIZATION

SECTION D

a) Name & Address of Hospital where Admitted

City | State

Pin Code | Land Mark

b) Room Category occupied ☐ Day care ☐ Single occupancy ☐ 3 or more beds per room ☐ Any other category, Pls specify _____

c) Hospitalization due to ☐ Injury ☐ Illness ☐ Maternity | d) Date of Injury/Date Disease first detected (D D M M Y Y Y Y)

e) Date of Admission (D D M M Y Y Y Y) Time (H H : M M) | f) Date of Discharge (D D M M Y Y Y Y) Time (H H : M M)

g) In case of maternity, 1 Date of Delivery (D D M M Y Y Y Y) | 2 Gravida Status _____

h) If Injury, give cause ☐ Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption

1. If Medico legal ☐ Yes ☐ No 2. Reported to police ☐ Yes ☐ No 3. MLC Report & Police FIR attached ☐ Yes ☐ No

i) System of Medicine _____

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

1. Pre-hospitalization Expenses	Rs.	2. Hospitalization Expenses	Rs.
3. Post-hospitalization Expenses	Rs.	4. Health-Check up Cost	Rs.
5. Ambulance Charges	Rs.	6. Others	Rs.
		Total amount claimed	Rs.

b) Claim for Domiciliary Hospitalization ☐ Yes ☐ No (If yes, please provide summary of bills in separate sheet)

c) Details of Lump sum / cash benefit claimed:

1. Hospital Daily Cash	Rs.	2. Surgical Cash	Rs.
3. Critical Illness Benefit	Rs.	4. Convalescence	Rs.
5. Pre/Post hospitalization Lump sum benefit:	Rs.	6. Others_____	Rs.
		Total amount claimed	Rs.

No of days (Pre Hospitalisation)_____

No of days (Post Hospitalisation)_____

SECTION E

Check List of Claim Documents to be submitted (In original)* - Please tick relevant box
(For Hospital Cash benefit, photocopies of claim documents are acceptable)

- ☐ Claim Form Duly signed
- ☐ Advance payment Receipt **(Mandatory)**
- ☐ Pharmacy Bill
- ☐ Doctor's prescription for medicines purchased outside the hospital and investigation done outside hospital
- ☐ Cancelled Cheque leaf of the bank account held in the name of the primary insured **(Mandatory)**
- ☐ CKYC Registration Number of the Proposer (In case already registered for CKYC - enter register numbers):
- ☐ CKYC Registration Number is not available
  CKYC documents – Address proof and ID proof along with duly filled CKYC Registry Form with recent colour PP size photograph (for claims exceeding Rs.1 Lakh only)
- ☐ Copy of the claim intimation, if any
- ☐ Final Bill Payment Receipt **(Mandatory)**
- ☐ Doctor's request for investigation
- ☐ Original Death Summary (Wherever applicable)
- ☐ Hospital Main Bill ☐ Hospital Break-up Bill
- ☐ Hospital Discharge Summary
- ☐ Investigation Reports (Including CT/MRI/USG/HPE/ECG)
- ☐ Test report and prescription relating to first consultation for the illness
- ☐ FIR/MLC in case of accident injury and English translation of the same if it is in any other language

***Please retain copy of complete set of claim documents for your records**

DETAILS OF BILLS ENCLOSED

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
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		Pharmacy Bills: (Nos_____)	
5		D D M M Y Y Y Y			

Hospital Main Bill Payment Receipts only

Receipt No	Date	Amount	Please Tick Relevant Box
	D D M M Y Y Y Y		☐ Advance Receipt ☐ Final Receipt
	D D M M Y Y Y Y		☐ Advance Receipt ☐ Final Receipt
	D D M M Y Y Y Y		☐ Advance Receipt ☐ Final Receipt
	D D M M Y Y Y Y		☐ Advance Receipt ☐ Final Receipt

Note : Please attach separate sheet if necessary

SECTION F

PLEASE PROVIDE YOUR BANK DETAILS: (PLEASE ATTACH CANCELLED CHEQUE LEAF OF BANK ACCOUNT IN THE NAME OF PRIMARY INSURED WITHOUT FAIL)

a) PAN b) Account Number

c) Bank Name and Branch

d) IFSC Code

SECTION G

DECLARATION BY THE INSURED

I hereby declare that the information furnished in this claim form 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 & 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 D D M M Y Y Y Y Place

Signature of primary insured /proposer

SECTION H

To ensure priority processing, please complete all sections in CAPITAL letters. Please tick ☑ in the relevant boxes.

CLAIM FORM – PART B

TO BE FILLED IN BY THE HOSPITAL

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

(Guidance for filling claim form- **Part B** is available on our website: www.royalsundaram.in)

Royal Sundaram
General Insurance

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital

b) Hospital ID
(For Office use only)

c) Type of Hospital ☐ Network ☐ Non Network (If non network fill section D)

d) Name of the treating Doctor

e) Qualification

f) Registration No. with State Code

g) Phone

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:

b) IP Registration Number

c) Gender ☐ Male ☐ Female d) Age Y Y Years M M Months e) Date of Birth D D M M Y Y Y Y

f) Type of Admission ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity

g) Date of Admission D D M M Y Y Y Y Time H H : M M

h) Date of Discharge D D M M Y Y Y Y Time H H : M M

i) If Maternity

1.Date of Delivery D D M M Y Y Y Y 2.Gravida Status _____

j) Status at time of discharge ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased

SECTION C

DETAILS OF AILMENT DIAGNOSED

	ICD 10 Codes	Description	Duration
1. Primary Diagnosis			M M Y Y Y Y
2. Additional Diagnosis			M M Y Y Y Y
3. Co-morbidities			M M Y Y Y Y
4. Co-morbidities			M M Y Y Y Y
	ICD 10 PCS Codes		
1. Procedure(1)			
2. Procedure(2)			
3. Procedure(3)			
4. Details of any other Procedure			

a) Whether preauthorisation obtained ☐ Yes ☐ No. If yes, Preauthorisation No._____

b) If Authorisation by network hospital not obtained, please give reason_____

c) Hospitalization due to Injury ☐ Yes ☐ No If Yes, give cause _____

1. ☐ Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse/alcohol consumption

2. If Injury due to Substance abuse/alcohol consumption, Test Conducted to establish this: ☐ Yes ☐ No

If Yes, details of tests conducted_____

3. If Medico legal ☐ Yes ☐ No 4. Reported to Police ☐ Yes ☐ No 5. FIR No.

6. If not reported to police, give reason_____

d) When did the patient start suffering with the complaint? _____ Date of first consultation (prior to hospitalisation) D D M M Y Y Y Y

e) Please give previous medical history of the patient

f) Is the patient suffering from any of the following diseases. If "yes" Please mention the duration below.

		Say Yes/No	Duration in Year	Duration in Month
1.	Bronchial Asthma			
2.	Chronic Obstructive Pulmonary disease			
3.	Hypertension			
4.	Diabetes			
5.	Heart ailment			
6.	Arthritis of any kind			
7.	Cerebro vascular attack			
8.	Seizure disorder			
9.	Renal/Kidney Disorder			
10.	Congenital conditions			
11.	Developmental anomalies			
12.	Any other			

g) Is the ailment a complication / sequel of a pre-existing disease or condition? If Yes , please give details

h) History of alcoholism ☐ Yes ☐ No
If yes : No of years _____
Quantity consumed per day _____

i) History of Smoking/ Tobacco chewing ☐ Yes ☐ No
If yes : No of years _____
Units consumed per day _____

SECTION D

ADDITIONAL DETAILS IN CASE OF NON-NETWORK HOSPITAL

a) Address of the Hospital

b) Hospital Registration No

c) Hospital Registered with

City State

d) Hospital PAN e) Number of Inpatient beds

f) Facilities available in the hospital: 1. OT ☐ Yes ☐ No 2. ICU ☐ Yes ☐ No 3. Round the clock Doctor/Nurses ☐ Yes ☐ No
4. Maintains daily record of patients ☐ Yes ☐ No
5. Others _____

SECTION E

DECLARATION BY THE HOSPITAL **(PLEASE READ VERY CAREFULLY)**

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, insured's right to claim under this policy shall be for feited.

Date D D M M Y Y Y Y Place

Signature and Seal of the Hospital Authority