

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	<input type="checkbox"/> Hospitalization <input type="checkbox"/> Pre Hospitalization <input type="checkbox"/> Post Hospitalization <input type="checkbox"/> Health check-up <input type="checkbox"/> OPD		
b) Pre authorization obtained	<input type="checkbox"/> Yes <input type="checkbox"/> No	Period To	<input type="checkbox"/> Individual <input type="checkbox"/> Group
c) Policy type	<input type="checkbox"/> Individual <input type="checkbox"/> 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	<input type="checkbox"/> Upto ₹ 20,000 <input type="checkbox"/> ₹ 20,001 to ₹ 50,000 <input type="checkbox"/> ₹ 50,001 to ₹ 1,00,000 <input type="checkbox"/> ₹ 1,00,001 and above		

SECTION B - DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediciam/Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No		
b) Date of commencement of first insurance without break	DD / MM / YYYY		
c) If yes, Company Name			
Policy No		Sum Insured ₹	
d) Have you been hospitalized in the last four years since inception of the contact?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Date	DD / MM / YYYY	Diagnosis	
e) Previously covered by any other Mediciam/Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No		
f) If yes, Company Name			

SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED

a) Name			
b) Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	c) Age	____ Years ____ Months
d) Date of Birth	DD / MM / YYYY		



e) Relationship to Primary insured	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other - Please Specify _____		
f) Occupation	<input type="checkbox"/> Service <input type="checkbox"/> Self Employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> 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	<input type="checkbox"/> Day care <input type="checkbox"/> Single occupancy <input type="checkbox"/> Twin sharing <input type="checkbox"/> 3 or more beds per room		
c) Hospitalization due to	<input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Maternity		
d) Date of Injury/Date disease first detected /Date of delivery	DD / MM / YYYY		
e) Date of Admission	DD / MM / YYYY	f) Time	HH / MM AM/PM
g) Date of Discharge	DD / MM / YYYY	h) Time	HH / MM AM/PM
i) If injury give cause	<input type="checkbox"/> Self inflicted <input type="checkbox"/> Road traffic accident <input type="checkbox"/> Substance abuse /Alcohol consumption		
i. If Medico legal	<input type="checkbox"/> Yes <input type="checkbox"/> No	ii. Reported to police	<input type="checkbox"/> Yes <input type="checkbox"/> No
iii. MLC report & Police FIR attached	<input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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	₹



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		DD/MM/YYYY		Hospital main Bill	
2		DD/MM/YYYY		Pre hospitalization Bills _____Nos	
3		DD/MM/YYYY		Post hospitalization Bills _____Nos	
4		DD/MM/YYYY		Home care treatment Bills	
5		DD/MM/YYYY		Pharmacy Bills	
6		DD/MM/YYYY		Other expenses if any _____	
7		DD/MM/YYYY			
8		DD/MM/YYYY			
9		DD/MM/YYYY			
10		DD/MM/YYYY			

CLAIM DOCUMENTS SUBMITTED CHECK LIST

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



SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

1. Name of the Bank Account Holder	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	F I R S T	M I D D L E	L A S T
2. Bank Account No.:	3. Account:		<input type="checkbox"/> Saving <input type="checkbox"/> Current	<input type="checkbox"/> 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)				
<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please mention the position held	
Is any of your close relation or family member a PEP?	<input type="checkbox"/> Yes <input type="checkbox"/> 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



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.

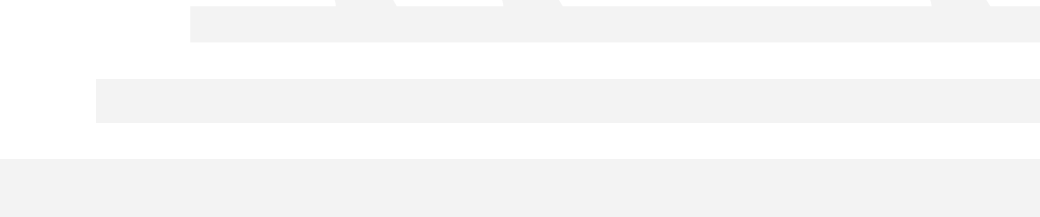
Date: _____

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.



Claim No.: _____

**HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND
PERSONAL ACCIDENT - PART B - 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. Please include the original preauthorization request form in lieu of PART A

SECTION A - DETAILS OF HOSPITAL

a) Name of the Hospital			
b) Hospital ID			
c) Type of Hospital	<input type="checkbox"/> Network <input type="checkbox"/> Non Network (if non network fill section E)		
d) Name of the treating doctor			
e) Qualification			
f) Registration No with state code		g) Phone No	
h) Email Id:			

SECTION B - DETAILS OF PATIENT ADMITTED

a) Name of the patient			
b) IP Registration Number		c) Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
d) Age	_____ Years _____ Months	e) Date of birth	DD / MM / YYYY
f) Date of Admission	DD / MM / YYYY	g) Time	HH / MM AM/PM
h) Date of Discharge	DD / MM / YYYY	i) Time	HH / MM AM/PM
j) Type of admission	<input type="checkbox"/> Emergency <input type="checkbox"/> Planned <input type="checkbox"/> Day care <input type="checkbox"/> Maternity		
k) If Maternity:			
i. Date of Delivery	DD / MM / YYYY	ii. Gravida Status	
l) Status at time of discharge	<input type="checkbox"/> Discharge to home <input type="checkbox"/> Discharge to another hospital <input type="checkbox"/> Deceased		
m) Total claimed amount	₹ _____/-		

SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY) - PART A

S. No.	ICD 10 Codes	Description
1	Primary Diagnosis	
2	Additional Diagnosis	
3	Co-morbidities	
4	Co-morbidities	

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SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY) - PART B

S. No.	ICD 10 Codes	Description
1	Procedure 1	
2	Procedure 2	
3	Procedure 3	
4	Details of procedure	

n) Pre - authorization obtained	<input type="checkbox"/> Yes <input type="checkbox"/> No
o) Pre - authorization number	
p) If authorization by network hospital not obtained, give reason	
q) Hospitalization due to injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. If Yes, give cause	<input type="checkbox"/> Self inflicted <input type="checkbox"/> Road traffic accident <input type="checkbox"/> Substance abuse/alcohol consumption
ii. If injury due to Substance abuse/alcohol consumption, Test conducted to establish this	<input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, attach reports)
iii. If Medico Legal	<input type="checkbox"/> Yes <input type="checkbox"/> No
iv. Reported to police	<input type="checkbox"/> Yes <input type="checkbox"/> No
v. FIR No	vi. If not reported to police, give reason

CLAIM DOCUMENTS SUBMITTED CHECK LIST

S. No.	Documents	S. No.	Documents
1	<input type="checkbox"/> Claim form duly signed	9	<input type="checkbox"/> Investigation reports
2	<input type="checkbox"/> Original pre authorization request	10	<input type="checkbox"/> CT/MRI/USG/HPE investigation reports
3	<input type="checkbox"/> Copy of pre - authorization approval letter	11	<input type="checkbox"/> Doctor's reference slip for investigation
4	<input type="checkbox"/> Copy of photo ID card of patient verified by hospital	12	<input type="checkbox"/> ECG
5	<input type="checkbox"/> Hospital discharge summary	13	<input type="checkbox"/> Pharmacy bills
6	<input type="checkbox"/> Operation theatre notes	14	<input type="checkbox"/> MLC report & police FIR
7	<input type="checkbox"/> Hospital main bill	15	<input type="checkbox"/> Original death summary from hospital where applicable
8	<input type="checkbox"/> Hospital break up bill	16	<input type="checkbox"/> Any other, please specify



SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON NETWORK HOSPITAL)

a) Address of the Hospital			
City	State		
Pin Code			
b) Phone No	c) Registration No with state code		
d) Hospital PAN	e) Number of Inpatients bed		
f) Facilities available in the hospital			
i) OT: <input type="checkbox"/> Yes <input type="checkbox"/> No ii) ICU: <input type="checkbox"/> Yes <input type="checkbox"/> No iii) Others: _____			

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We hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact our right to claim under this claim shall be forfeited.

Date: _____

Place: _____

Signature & Seal of Hospital Authority

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.

