Individual personal Accident
Claim Form

ApolloMunich HEALTH INSURANCE
www.apollomunichinsurance.com

Issuance of this form does not amount to admission of any liability or a waiver of any of the terms and conditions of the insurance contract. If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or any Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy shall be void and all benefits paid under it shall be forfeited.
Please give the following information correctly and completely to enable us to process your claim promptly.

SECTION I: To be completed by the Policyholder / Insured Person or his representative

1. Details of the Policyholder

Policy Number (in full): _____

Employee Number (for Group Policies): _____

Name of Policyholder: _____

Address: _____

_____

Date of Birth (DD/MM/YYYY): _____ Occupation: _____

Telephone No.: _____ Mobile No.: _____ E-Mail: _____

2. Details of Insured Person in respect of whom the claim is made

Name of Insured Person: _____

Address: _____

_____

Date of Birth (DD/MM/YYYY): _____ Occupation: _____

Telephone No.: _____ Mobile No.: _____ E-Mail: _____

Relationship with the Policyholder: _____

Date (DD/MM/YYYY) & time of injury/death: _____

Place/Address of accident/ death: _____

Details of the accident and nature of accident (Continue on a separate sheet if necessary): _____

_____

Did the accident happen when you were working? ☐ Yes ☐ No

If Yes: Name & address of Employer: _____

Whether reported to Police: ☐ Yes ☐ No

If Yes: Name and address of Police Station: _____

If not, please give reasons: _____

First Information Report (FIR) Number and Date: _____

Contact details of Police Station: _____

_____

3. Was the Insured Person moved to hospital immediately after the accident?

☐ Yes ☐ No (If Yes, please complete the following)

Name & address of the Hospital: _____

Date of Admission (DD/MM/YYYY): _____ Date of Discharge (DD/MM/YYYY): _____

4. Witnesses

Were there any witnesses to the event? ☐ Yes ☐ No (If Yes, please complete the following)

Name: _____

Address: _____

Pincode: _____ Place of witness: _____

Phone No. : (Home)_____ (Work) _____ (Mobile) _____

Please attach all original witness statements if already obtained. In case of further witnesses please use separate sheet.

5. Do you at present have any other Personal Accident policy?

☐ Yes ☐ No (If Yes, please complete the following)

Name & Address of the insurer and issuing office: _____

_____

Policy No.: _____

Policy Period: _____ Sum Insured: _____

Individual personal Accident
Claim Form

ApolloMunich HEALTH INSURANCE
www.apollomunichinsurance.com

6. For which benefits do you claim? [Please tick (P) the appropriate box]

Benefit	Amount	Benefit	Amount
☐ Accidental Death		☐ Accident Hospital Cash	
☐ Permanent Total Disablement		☐ Accident Medical Expenses	
☐ Permanent Partial Disablement		☐ Accident Hospitalization (In-patient)	
☐ Temporary Total Disablement		☐ Accident Hospitalization (Out-patient)	
☐ Permanent Serious Disablement		☐ Broken Bones	
☐ Transportation of Mortal Remains		☐ Widowhood Cover	
☐ Cremation Ceremony		☐ Marriage Expenses for Children	
☐ Emergency Ambulance Charges		☐ Carrier	
☐ Education Fund		☐ Coma	
☐ Family Transportation		☐ Modification of Residence / Vehicle	
☐ Purchase of Blood		☐ Others	
☐ Transportation of Imported Medicine		**Total Claimed Amount**	
☐ Cost of Wheelchair / Crutches			

Please attach the following documents [please tick (✓) the appropriate box]

List - I (Accidental Death)
- ☐ Duly filled and signed Claim Form
- ☐ Policy copy
- ☐ Copy of FIR (First Information Report) /Spot Panchnama / Inquest Panchnama
- ☐ Death Certificate
- ☐ Original death summary
- ☐ Post Mortem Report
- ☐ Original legal heir certificate (in case nomination has not been filed by deceased)

List - II (Permanent Total Disablement/ Permanent Partial Disablement/Temporary Total Disablement/ Permanent Serious Disablement)
- ☐ Duly filled and signed Claim Form
- ☐ Policy Copy
- ☐ Copy of FIR (First Information Report)
- ☐ Original treating doctor certificate describing disablement
- ☐ Original Discharge summary from the hospital
- ☐ Original photograph of the injured reflecting disablement
- ☐ Prescription and consultation papers
- ☐ Leave certificate from the employer (If Employed)
- ☐ Disability Certificate issued by Civil Surgeon or equivalent as authorised by State Government
- ☐ Medical reports, case histories, investigation reports, treatment papers as applicable.

List - III (Transportation of Mortal Remains)
- ☐ All Documents of List - I, plus
- ☐ Original Bills and payment receipt of transportation

List - IV (Cremation Ceremony)
- ☐ All Documents of List - I, plus
- ☐ Original Bills and payment receipt

List - V (Emergency Ambulance Charges)
- ☐ All documents of List - I or List - II , plus
- ☐ Original Bills and payment receipt
- ☐ Treating Doctor's consultation indicating Emergency care

List - VI (Education Fund)
- ☐ All documents of List - I or List - II , plus
- ☐ Study Certificate from the school of the dependent child mentioning the parent's name

List - VII (Family Transportation)
- ☐ All documents of List - I or List - II , plus
- ☐ Original Bills and payment receipt
- ☐ Proof of the immediate family member such as Ration Card

List - VIII (Purchase of Blood)
- ☐ All documents of List -I or List - II , plus
- ☐ Original Bills and payment receipt
- ☐ Prescription of the doctor mentioning the indication

List - IX (Transportation of Imported Medicine)
- ☐ All documents of List - I or List - II , plus
- ☐ Prescription of the doctor mentioning the indication
- ☐ Bill of Loading
- ☐ Original Medicine bill and payment receipt
- ☐ Reason for Import

List - X (Cost of Wheel Chair / Crutches)
- ☐ All documents of List - II , plus
- ☐ Original Bills and payment receipt
- ☐ Prescription of the doctor mentioning the indication

List - XI (Accident Hospital Cash)
- ☐ Duly filled and signed Claim Form
- ☐ Policy Copy
- ☐ Copy of the Discharge Summary
- ☐ Copy of First Information Report (FIR) / Medico-Legal certificate (MLC)
- ☐ If MLC not done, Treating doctor certificate giving details of Injury Sustained

List - XII (Accident Medical Expenses / Hospitalization -Inpatient)
- ☐ Same as the documents of List - II , plus
- ☐ Medical Bills with Prescription
- ☐ Medical Investigations report with prescription
- ☐ First Consultation and subsequent prescription

List - XIII (Accident Hospitalization - Out-patient)
- ☐ Same as the documents of List - XII except discharge summary

List - XIV (Broken Bones)
- ☐ Same as the documents of List - II , plus
- ☐ X-ray reports and films reflecting the fracture/s

List - XV (Widowhood Cover)
- ☐ Same as the documents of List - I , plus
- ☐ Marriage certificate

List - XVI (Marriage Expenses for Children)
- ☐ All documents of List - I or List - II , plus
- ☐ Proof of unmarried dependent Children [Affidavit and Age proof]

List - XVII (Common Carrier)
- ☐ Duly filled and signed Claim Form
- ☐ Policy Copy
- ☐ Original Ticket
- ☐ Copy of the Documents proving transportation of the Insured in the carrier

List –XVIII (Coma)
- ☐ Duly filled and signed Claim Form
- ☐ Policy Copy
- ☐ Copy of FIR (First Information Report)
- ☐ Prescription and consultation papers mentioning neurological findings
- ☐ Investigations report / neurological assessment report
- ☐ Clinical summary of the comatose patient from the treating Neurophysician / Neurosurgeon
- ☐ Proof of hospitalization

List - XIX (Modification of Residence/ Vehicle)
- ☐ All documents of List - II , plus
- ☐ Original Bills and payment receipt

Individual personal Accident
Claim Form

ApolloMunich HEALTH INSURANCE
www.apollomunichinsurance.com

CUSTOMER IDENTIFICATION PROCEDURE (AS PER KYC NORMS OF IRDA)

Please submit clear and legible copy of one document (valid and effective as on date of claim submission) each from Part A and Part B and your recent passport size photograph (not more than 6 months old) incase claim amount exceeds Rs 100,000.

Photograph

Part A **Proof of legal name and any other names used**	i. Pan Card ii. If Pan Card is not available please submit any of the documents mentioned below stating reason for not having Pan Card. a) Passport b) Voter's Identity Card c) Driving License d) Personal Identification and Certification of the employees for your identity. e) Letter issued by Unique identification Authority of India containing details of name address and Aadhar Number f) Job Card issued by NREGA duly signed by an officer of the State Government
Part B **Proof of Residence**	i. Electricity Bill not older than 6 months from the date of Insurance Contract ii. Telephone Bill pertaining to any kind of telephone connection like mobile, landline, wireless etc. Provided it is not older than 6 months from the date of claim submission iii. Ration Card iv. Valid lease agreement along with rent receipts which is not more than 3 months old as a residence proof v. Saving Bank Passbook with details of permanent/ present residence address (updated upto 1 month prior to claim submission document) vi. Statement of saving bank account with details of present/ present address (updated upto 1 month prior to claim submission document)

hereby declare that I have submitted above mentioned documents and recent photograph (not more than 6 months old) for the purpose of claim and the said documents are valid and effective.

Date : _____ Signature of Policyholder : _____

7. Direct payment in your bank account (optional)

Please provide the following details of your bank account and attach a cancelled cheque pertaining to the same account.

Bank Name _____ Bank Branch _____

Bank Account Number _____ IFSC Code _____ MICR No. _____

Note: It is agreed that the Policyholder/ Claimant will intimate in writing to Apollo Munich Health Insurance Co. Ltd. about any change in bank account details.

Declaration

I/We hereby warrant that:

(1) I have read and understood the policy terms, conditions and exclusions
(2) The foregoing particulars are true and complete in all material respects.

Date: Place:

Signature of the Insured Person:

I/We hereby warrant that:

(1) I have read and understood the policy terms, conditions and exclusions
(2) The foregoing particulars are true and complete in all material respects.

Date: Place:

Signature of the Policyholder:

SECTION II: To be completed by Nominee in the event of Policyholder's death

Name of Nominee: _____

Address: _____

_____

Date of Birth (DD/MM/YYYY): _____ Relationship with the deceased: _____

Telephone No.: _____ Mobile No.: _____ E-Mail: _____

Declaration to be signed by the Nominee (in the event of Insured's death)

I/We hereby warrant that:
(1) I have read and understood policy terms, conditions and exclusions and

Individual personal Accident
Claim Form

ApolloMunich HEALTH INSURANCE
www.apollomunichinsurance.com

(2) That the forgoing particulars are true and complete in all material respects, and
I also authorise Apollo Munich Health Insurance Company Ltd to make payment of the claim admissible as per terms, conditions and limitations to the Insured Person or his legal heirs as full and final settlement. I/We will keep indemnified and hold Apollo Munich Health Insurance Company Ltd. harmless from any claim under this Policy by any third party.

Date: Place:

Signature of the Nominee:

SECTION III: To be completed by the Doctor who originally treated the injuries

1) Name and address of the Injured Person: _____
2) Gender: ☐ Male / ☐ Female
3) Date of Birth (DD/MM/YYYY) and age: _____
4) Are you the patient's usual medical attendant? ☐ Yes ☐ No
   a) If Yes, since when (DD/MM/YYYY)? _____
   b) If you have treated him/her for any previous illness or injury, please give details: _____
5) Has the patient sustained a similar injury previously or aggravated a pre-existing condition? ☐ Yes ☐ No
6) Describe nature and extent of injury: _____
   a) If limb or eye is injured, please state whether right or left: _____
7) Nature and cause of accident (so far as it is known to you): _____
8) Are his/her injuries
   a) Solely due to the accident? ☐ Yes ☐ No
   b) Traceable to any disease, infirmity previous injuries or any other cause? ☐ Yes ☐ No
   c) If Yes, please give details: _____
9) Injuries sustained in this accident are the sole cause of disablement? _____
10) Date you first examined the patient for this injury (DD/MM/YYYY): _____
    If admitted in Hospital: Date of Admission (DD/MM/YYYY): _____ Date of Discharge (DD/MM/YYYY): _____
11) According to you, how long should the injured person be confined to bed/house as the direct and sole consequence of the injury sustained?
    From (DD/MM/YYYY) : _____ To (DD/MM/YYYY) : _____
    a) During this period will the injured person be able to attend to his/her normal duties? ☐ Yes ☐ No
    b) If Yes, from what date (DD/MM/YYYY) : _____
    c) If No, please state probable date of his/her being able to attend to his/her normal duties (DD/MM/YYYY): _____
12) Is Claimant suffering from any disease or illness apart from his injury and is there any illness by circumstances which may tend to retard recovery? ☐ Yes ☐ No
    a) If Yes: Give particulars: _____
13) Present Condition: _____
14) Was he/she under the influence of intoxicants or drugs at the time of accident? _____
15) Nature of disablement _____
    a) Permanent Total Disablement ☐ Yes ☐ No
    b) Permanent Partial Disablement ☐ Yes ☐ No
    c) Please specify percentage: _____ **%**

I have personally examined the above named Insured Person. I certify that the above statements are correct and that the Insured Person is necessarily disabled by the Accident.

Date: Place:

Signature of the Doctor:

Name & Qualification: _____
Registration Number: _____
Address: _____

Telephone No.: _____ Mobile No.: _____ E-mail: _____

Stamp:

We would be happy to assist you. For any help contact us at: E-mail : customerservice@apollomunichinsurance.com Toll Free : 1800-102-0333

AMHI/PR/H/0018/0003/1020ID/P