Easy Domestic Travel Insurance
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 Policy. 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 the 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. We may call for additional document/information as required. Use additional sheet, if required.

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

1. Details of the Policyholder

Policy no:

Name of policy holder:

2. Details of Insured Person / claimant (if the claimant is other than the Insured Person): Have your registered communication address, mobile number or e-mail id been changed: yes/no

If yes, please provide latest modified details:

Name: (Mr./Ms./Mrs.)

First Name **Middle Name** **Last Name**

Address

Mobile No.: **Telephone No.:**

PAN No.: **Aadhaar no. :**

Occupation:

3. Policy holder bank details / Nominee bank details in case of death:

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

Name as in Bank Account:

Bank Name:

Bank Branch:

Bank Account Number:

IFSC: **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

4. For which benefits do you want to claim for? [Please tick (☐) the appropriate box]

Benefit	Benefit
☐ Medical Treatment	☐ Personal Accident
☐ Flight delay	☐ Personal Accident - Carrier
☐ Medical Evacuation	☐ Personal Liability
☐ Transportation of Mortal Remains	☐ Trip Cancellation
☐ Total Loss of Checked-in Baggage	☐ Trip Delay
☐ Delay of Checked-in Baggage	☐ Trip Curtailment
☐ Emergency Hotel	☐ Others
☐ Emergency Travel	

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Please attach the following documents as per benefit

List – I (Medical Treatment) ☐ Doctor's reports ☐ Original admission / discharge card ☐ Original bills / receipts / with prescriptions and diagnostic /investigative reports ☐ Copy ticket and boarding pass/address proof. ☐ Copy of FIR/Police Report (if accidental)	**List – II (Medical Evacuation/Transportation of Mortal Remains)** ☐ All documents in list I ☐ Name of airline ☐ Burial details with bifurcation of incurred Expenses ☐ Death certificate (if claiming for repatriation of mortal remains) ☐ Death Summary (if claiming for repatriation of mortal remains) ☐ Treating Doctor Certificate mentioning need of medical evacuation
List – III (Total Loss or Delay of Checked-in Baggage) ☐ Original invoice/receipts with the details of individual items purchased during the delay period/individual items lost ☐ Copies of baggage tags ☐ Copies of correspondence with airline authorities/others about loss/delay of checked-in baggage ☐ Details of compensation received from airlines/ other authorities (if any) ☐ Property Irregularity Report (obtained from airline) ☐ Copy ticket and boarding pass/address proof. ☐ Adequate proof of ownership of items contained within checked-in-baggage valued in excess of Rs. 2000 & address proof.	**List – IV (Trip Delay/Trip Cancellation and Curtailment/Flight Delay)** ☐ Detailed report/confirmation from the airline/Hospital/Police/others of incident which leads to the delay/cancellation/curtailment of the flight/trip ☐ Copies of correspondence with airline authorities/others about delay/ cancellation/curtailment, along with details of compensation received from airlines/other authorities (if any) ☐ Original admission/discharge card, diagnostic/investigative reports of hospitalization ☐ Death certificate (in case of death) ☐ Invoices and receipts. ☐ Copy of ticket and boarding pass/address proof.
List – V (Emergency Travel and Emergency Hotel) ☐ Doctor's reports ☐ Original admission / discharge card ☐ Diagnostic / investigative reports ☐ Copy of the ticket and boarding pass ☐ Invoices / receipts & address proof.	**List – VI (Personal Liability/Personal Accident and Common Carrier)** ☐ Please attach Police report ☐ Post Mortem Report (in case of death) ☐ Death certificate (in case of death) ☐ All consultations and medical reports/ medical report in enclosed format ☐ Original discharge summary from the hospital (in case of hospitalization) ☐ Certificate from treating Doctor for Permanent Disability ☐ Original photograph of the injured reflecting disablement ☐ Copy of FIR/Police Report (if accidental and applicable) ☐ Succession Certificate (in case of death of insured). ☐ Judgment of the Court for Personal Liability. ☐ Copy of ticket and boarding pass/ address proof.

Declaration

I, the undersigned, authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to Apollo Munich Health Insurance Company Limited or its representatives, any and all information with respect to any injury or illness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, illness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, including to determine eligibility for benefit payments under the Policy Number identified above. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization

I hereby declare and warrant that:

(1) I have read and understood the terms, conditions and exclusions of this Policy, and

(2) that the foregoing particulars are true and complete in all material respects, and

(3) There is no other insurance in force that may apply to this claim.

Date: Signature:

Place:

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SECTION I.

Medical Treatment/ Medical Evacuation/Transportation of Mortal Remains/ Personal Liability/Personal Accident and Common Carrier

I. Nature of the claim being made:

II. Details for medical treatment:

Name of the doctor/physician/dentist:

Name/Address of the hospital/clinic:

Contact no. of hospital/ doctor/Dentist/Physician:

Name of the disease:

Treatment start date: D D M M Y Y Y Y Treatment end date: D D M M Y Y Y Y

III. Whether the patient was admitted in hospital – ☐ Yes ☐ No If Yes, please share below mentioned details:

Date of admission: D D M M Y Y Y Y **Time of admission:** A M P M

Date of discharge: D D M M Y Y Y Y **Time of discharge:** A M P M

IV. If accident, please share below mentioned details:

Date of Injury/Death : D D M M Y Y Y Y **Time of Injury/Death:** A M P M

Place of Injury/Death :

Details/Narration of Injury/Death:

V. Whether the case is reported to Police: ☐ Yes ☐ No (If Yes, please complete the following)

If Yes, Name of Police Station:

Address of Police Station :

FIR No: **Date:** D D M M Y Y Y Y

VI. If claiming for Medical Evacuation, please share reason for medical evacuation:

Date of evacuation: D D M M Y Y Y Y

VII. If claiming for Personal Liability, detail of the court where case pursued:

Note - Please provide the cost details for the Expenses (bills, invoices, prescriptions etc.) in Section III of this claim form and mention the currency for medical treatment.

SECTION II. - To be completed by the Policyholder / Insured Person or his representative

Flight details:

Name of the carrier:

Flight number: From: D D M M Y Y Y Y To: D D M M Y Y Y Y

Scheduled departure date: D D M M Y Y Y Y Time: A M P M

Scheduled arrival date: D D M M Y Y Y Y Time: A M P M

Actual departure date: D D M M Y Y Y Y Time: A M P M

Actual arrival date: D D M M Y Y Y Y Time: A M P M

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1. Total Loss or Delay of Baggage

Date of loss: D D M M Y Y Y Y Location of loss:

Date of Checked-in Baggage retrieval: D D M M Y Y Y Y Time of Checked-in Baggage retrieval: A M P M

Number of Checked-in Baggage:

Description of the items lost with regards to number, nature and cost of each item:

Description of items purchased with regards to number, nature and cost of each item:

Amount refunded by carrier:

Total Claim Amount:

2. Trip Delay/Trip Cancellation and Curtailment/Flight Delay:

Reason of trip delay/cancellation/curtailment:

Note - Please provide the cost details for the Expenses (bills, invoices, prescriptions etc) in Section III of this claim form and mention the currency.

3. Emergency Travel and Emergency Hotel:

Details for medical treatment:

Name of the disease/Nature of injury:

Name of the doctor/Physician/Dentist:

Name/Address of the hospital/clinic:

Contact no. of hospital/ doctor/Dentist/Physician:

Date of admission: D D M M Y Y Y Y Date of discharge: D D M M Y Y Y Y

Relationship with Insured:

Note - Please provide the cost details for the Expenses (bills, invoices, prescriptions etc) in Section III of this claim form and mention the currency.

SECTION III.

Details of Expenses

S. No.	Expense Details	Issued by	Currency	Amount	Amount of received reimbursement	Remarks

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SECTION IV: Medical Report (to be filled by Treating Doctor)

1) Name of the patient: _____

2) Gender: ☐ Male / ☐ Female

3) Date of Birth (DD/MM/YYYY) and age: _____

4) Diagnosis: _____

5) Treatment Start: _____ Treatment End: _____

6) If hospitalized than –

Date of admission: _____ Date of discharge: _____

7) History of presented complaints: _____

_____

8) Is the present condition due to any pre-existing condition? ☐ Yes ☐ No If Yes, provide details: _____

_____

9) Is the present condition due to pregnancy? ☐ Yes ☐ No If Yes, provide details: _____

10) If accidental than, please share below mentioned details: _____

- Date of accident: _____ Time of accident: _____
- Was the patient under influence of alcohol/drugs at the time of the accident? ☐ Yes ☐ No
- Are the injuries suffered/death solely due to the accident? ☐ Yes ☐ No If No, provide details: _____

_____

- Is the injured person totally disabled from each and every occupation? ☐ Yes ☐ No
- Specify the body part permanently impaired: _____

I hereby to the best of my knowledge and belief, warrant the truth of the above details in every respect.

Place:

Date:

Name: _____

Signature of Doctor:

Stamp:

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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 INR 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 claim submission 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 : _____