

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 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. Use additional sheet, if required. We may call for additional document/information as required.

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

1. Details of the Policy

Policy no:

Name of policy holder:

2. Details of Insured Person / claimant

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

First Name	Middle Name	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>

Address (in India):

Mobile No. (in India) : **Mobile No. (in abroad):**

E-mail:

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

Passport No.:

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	Benefit
<input type="checkbox"/> Medical Treatment	<input type="checkbox"/> Personal Accident and Common Carrier	<input type="checkbox"/> Trip Delay
<input type="checkbox"/> Dental Treatment	<input type="checkbox"/> Personal Liability	<input type="checkbox"/> Trip Curtailment
<input type="checkbox"/> Medical Evacuation	<input type="checkbox"/> Hijack Daily Allowance	<input type="checkbox"/> Hospital Daily Allowance
<input type="checkbox"/> Repatriation of Mortal Remains	<input type="checkbox"/> Financial Emergency Cash	<input type="checkbox"/> Loss of Passport
<input type="checkbox"/> Loss or Delay of Baggage	<input type="checkbox"/> Missed Connection	<input type="checkbox"/> Others
<input type="checkbox"/> Trip Cancellation		

Please attach the following documents as per benefit

<p>List – I (Medical Treatment/Dental Treatment/Hospital Daily Allowance)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Doctor's reports <input type="checkbox"/> Original admission / discharge card <input type="checkbox"/> Original bills / receipts / with prescriptions and diagnostic /investigative reports <input type="checkbox"/> Copy of passport / visa with entry and exit stamp and copy of the ticket and boarding pass <input type="checkbox"/> Copy of FIR/Police Report (if accidental) 	<p>List – II (Medical Evacuation/Repatriation of Mortal Remains)</p> <ul style="list-style-type: none"> <input type="checkbox"/> All documents in list I <input type="checkbox"/> Name of airline <input type="checkbox"/> Burial details with bifurcation of incurred Expenses <input type="checkbox"/> Death certificate (if claiming for repatriation of mortal remains) <input type="checkbox"/> Death Summary (if claiming for repatriation of mortal remains) <input type="checkbox"/> Treating Doctor Certificate mentioning need of medical evacuation
<p>List – III (Total Loss or Delay of Checked-in Baggage)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Original invoice/receipts with the details of individual items purchased during the delay period/individual items lost <input type="checkbox"/> Copies of baggage tags <input type="checkbox"/> Copies of correspondence with airline authorities/others about loss/delay of checked-in baggage <input type="checkbox"/> Details of compensation received from airlines/ other authorities (if any) <input type="checkbox"/> Property Irregularity Report (obtained from airline) <input type="checkbox"/> Copy of the passport/visa with entry and exit stamp and copy of the ticket and boarding pass.. <input type="checkbox"/> Adequate proof of ownership of items contained within checked-in baggage valued in excess of the Indian rupee equivalent of US \$ 100 for loss of checked-in baggage.. 	<p>List – IV (Loss of Passport/Financial Emergency Cash)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Please attach Copy of new passport <input type="checkbox"/> Copy of previous passport (if available) <input type="checkbox"/> Original bills/invoices of expenses incurred for obtaining a new passport <input type="checkbox"/> Copy of FIR/police report. <input type="checkbox"/> Death certificate (in case of death) <input type="checkbox"/> Invoices and receipts. <input type="checkbox"/> Copy of the ticket and boarding pass. <p>List – VI (Hijack Daily Allowance)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Police report with details such as passport number and period of hijacking <input type="checkbox"/> Copy of the passport/visa with entry and exit stamp and copy of the ticket and boarding pass. <input type="checkbox"/> Newspaper reports/TV Clip or any other media coverage (if available)
<p>List – V (Personal Liability/Personal Accident and Common Carrier)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Post Mortem Report (in case of death) <input type="checkbox"/> Death certificate (in case of death) <input type="checkbox"/> All medical reports/ medical report in enclosed format <input type="checkbox"/> Certificate from treating Doctor for Permanent Disability <input type="checkbox"/> Original photograph of the injured reflecting disablement <input type="checkbox"/> Copy of FIR/Police Report (if accidental and applicable) <input type="checkbox"/> Judgment of the Court for Personal Liability. <input type="checkbox"/> Copy of the passport/visa with entry and exit stamp and copy of the ticket and boarding pass. 	<p>List – VII (Trip Delay/Trip Cancellation and Curtailment/Missed Connection)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Detailed report/confirmation from the carrier/Hospital/Police/others of incident which leads to the delay/cancellation/curtailment of the flight/trip <input type="checkbox"/> Copies of correspondence with airline authorities/others about delay/ cancellation/curtailment, along with details of compensation received from airlines/other authorities (if any) <input type="checkbox"/> Original admission/discharge card, diagnostic/investigative reports of hospitalization <input type="checkbox"/> Death certificate (in case of death) <input type="checkbox"/> Copy of the passport/visa with entry and exit stamp and copy of the ticket and boarding pass.

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 to determine eligibility for benefit payments under the Policy Number identified above. I understand 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: _____

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. Hijack Daily Allowance

Date of Hijack: Date of return:

Description of incident:

4. Loss of Passport/Financial Emergency Cash

Date of Loss: Place of Loss:

Description of circumstances of loss:

Application document fee: Incidental cost:

Amount of the fund lost: Total claimed amount:

5. Personal Liability

Details for medical treatment:

Date of accident : **Time of accident:**

Place of Injury/accident :

Name of Police Station:

Address of Police Station :

Details/Narration of accident:

Detail of the court where case pursued:

SECTION III.

Details of Expenses

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

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

- 1) Name of the patient person: _____
- 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: _____

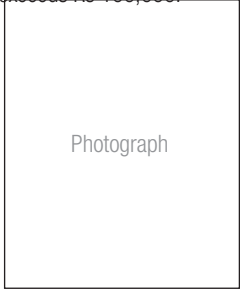
Name: _____

Signature of Doctor: _____

Stamp:

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.



<p>Part A Proof of legal name and any other names used</p>	<ul style="list-style-type: none"> 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. <ul style="list-style-type: none"> 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
<p>Part B Proof of Residence</p>	<ul style="list-style-type: none"> 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)

I 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 :
