

Claim Form [E-Opinion]



(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.)

Please give the following information correctly and completely to enable us to process your claim promptly

1. Policy Number (in full): _____ 2. HDFC ERGO Health Insurance Ltd. Member ID: _____
 3. Name of the Policyholder (in whose name policy is issued): _____

4. Details of the Insured Person (in respect of whose claim is made):

- i) Name of the Insured person: _____
 ii) Relationship with the Policyholder: _____
 iii) Date of Birth /Age: _____
 iv) Occupation: _____
 v) Current Residential Address & Contact Details (Telephone/Mobile No./E-Mail): _____

5. Please tick the (✓) specific Critical Illness benefit for which you are claiming

- | | |
|----------------------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Cancer of specified severity | <input type="checkbox"/> Stroke resulting in Permanent Symptoms |
| <input type="checkbox"/> Kidney Failure requiring regular dialysis | <input type="checkbox"/> Permanent Paralysis of Limbs |
| <input type="checkbox"/> Multiple Sclerosis with Persisting Symptoms | <input type="checkbox"/> Open Chest CABG |
| <input type="checkbox"/> First Heart Attack of specified severity | <input type="checkbox"/> Major Organ/Bone Marrow Transplant |

6. Details of clinical symptoms:

Chief Complaints	Signs & Symptoms:	Duration

7. Please give names and contact details of all doctors whom you have consulted:

Name	Address	Qualification	Telephone No

Please submit copies of all consultations.

8. Details of Previous Hospitalizations (If any)

Date of Admission	Date of Discharge	Diagnosis and Treatment	Name & Address of the Hospital

Please submit copies of all discharge summaries.

9. Details of Investigations done

Investigation Reports of the last one Year attached Yes / No

10. Is the patient suffering from any of the following?

- i) Hypertension: Yes / No If Yes, Since when _____
 ii) Diabetes: Yes / No If Yes, Since when _____
 iii) Heart Disease: Yes / No If Yes, Since when _____
 iv) Any other chronic ailment: Yes / No
 If Yes, (Please specify): _____ Since when _____

11. Personal History

- i) Alcoholism: Yes / No
 ii) Smoking: Yes / No
 iii) Tobacco chewing: Yes / No

12. No. of Documents submitted including this CLAIM FORM: _____

13. Current Clinical Diagnosis: _____

