HDFC ERGO General Insurance Company Limited

GROUP MEDICLAIM INSURANCE

INSURED'S INFORMATION

Name of Policyholder:

Policy No.: Certificate No.: (If applicable)

CLAIMANT INFORMATION

Name of Patient:

Occupation: Date of Birth: D D M M Y Y Y Y Present completed age:_____

Address and phone number:

Relationship to the Policyholder: ☐ Member/ Employee ☐ Spouse ☐ Dependent Child ☐ Dependent Mother ☐ Dependent Father

1. Nature of sickness/ diseaes/ injury claimed for: _____

   Date on which Injury was sustained or disease or illness first detected: D D M M Y Y Y Y Date of first consultation: D D M M Y Y Y Y

   Name of Doctor:

   Address, Phone No. of Doctor:

   Qualification of the Doctor consulted:

2. Have you had any prior treatment for this or related conditions? ☐ Yes ☐ No

   Name of Doctor:

   Address, Phone No. of Doctor:

   Qualification of the Doctor: Date: D D M M Y Y Y Y

3. Are you making any other insurance claim as a result of this hospitalization/surgery?: ☐ Yes ☐ No

   Name of Insurance Company:

   Policy No.:

4. Was the hospitalization/ surgery a result of an accident? ☐ Yes ☐ No

5. Place of Accident: Date of Accident: D D M M Y Y Y Y

6. Details of hospitalisation:

   Name of Hospital/ Nursing Home:

   Address:

   Date of Admission: D D M M Y Y Y Y Date of Discharge: D D M M Y Y Y Y

7. CLAIM QUANTUM:

Date	Nature of expenses incurred	Billed By	Amount (`)
		Total	

(If space is insufficient, please attach separate list)

In support of the above claim, I enclose the following original documents (Please tick)

- ☐ Hospital Discharge Card
- ☐ Bills, Cash Memos, Receipt from Hospitals
- ☐ Cash Memos, Receipts from Pharmacists, Pathology and Investigation Centres
- ☐ Bills, Cash Memos, Receipts from attending Doctors, Surgeons, Anesthetists
- ☐ Doctor's prescriptions for medicines, pathological tests, hospitalisation, surgery, physiotherapy
- ☐ Any other documents. Please specify

I/ We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and I/We agree that if I/We have made, or in any further declaration the Company may require in respect of the said claim, shall make any false or fraudulent statement, or any suppression or concealment the Policy shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited.

AUTHORISATION

I HEREBY AUTHORISE on behalf of the patient: (1) Any empl oyer, medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organisation, institution or person, that has any records or knowledge of the patient and/or who has attended or may hereafter attend the patient to disclose such information to HDFC ERGO General Insurance Company; (2) HDFC ERGO General Insurance Company or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of the patient in relation to this claim. This authorisation shall bind the patient's successors and remains valid notwithstanding death or incapacity. A photoc opy or facsimile copy of this authorisation shall be as valid as the original.

Date: D D M M Y Y Y Y

Place:

Signature of Patient

This is to certify that the above-mentioned claim lodged by the Insured / Claimant is genuine and the same is recommended for reimbursement.

Date: D D M M Y Y Y Y

Place:

Authorised Signatory

Name of Attending Physician:

Address, Phone No.:

I certify that the above named patient _____, was seen by me on _____ and has been fully cured of the sickness/injury claimed for, which first incurred on _____

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Date: D D M M Y Y Y Y

Place:

SIGNED (Attending Physician)

Name of the Policy holder & Seal:

Date: D D M M Y Y Y Y

ATTENDING PHYSICIAN INFORMATION

HDFC ERGO General Insurance Company Limited

Consent for Mode of Claim Payment

Name of Insured

Policy Number

Claim Number

Beneficiary Name

Mode of Payment (Please tick for mode of payment) Cheque ☐ Fund Transfer ☐

(All Fields are Mandatory in case of Fund Transfer)

Insured's Name as per Bank Account

Bank Account Number

Branch Name

IFSC Code

Email address

Attachments
In Support of Bank Details
(Please tick the type of proof submitted) Cancelled Cheque ☐ Bank Passbook Copy ☐

Declaration: I Mr./ Mrs/ Ms. _____ undersigned, legal beneficiary of the above claim, declare that all details mentioned in this form are true and I agree to the mode of payment against the particular claim number mentioned above.

Signature of Beneficiary
Stamp Required in case of Company

Date: D D M M Y Y Y Y