ApolloMunich HEALTH INSURANCE
Apollo Munich Health Insurance Co. Ltd.
10th Floor, Tower-B, Building No. 10,
DLF Cyber City, DLF City Phase -II, Gurgaon, Haryana-122002

CLAIM FORM

(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. Apollo Munich Health 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. Nature of disease/illness contracted or injury sustained: _____

6. Date on which injury was sustained/disease or illness first detected: _____

7. Details of the Doctor:

   i) Name and address of the attending Medical Practitioner: _____

   ii) Qualification & telephone No.: _____

8. Details of the Hospital:

   i) In-patient Bill No.: _____

   ii) Name & Address of the Hospital/Nursing Home/Clinic where treatment is taken/being taken: _____

   _____

   _____

   iii) Date (DD/MM/YYYY) and time(HH:MM) of Admission in the Hospital: _____

   iv) Date (DD/MM/YYYY) and time(HH:MM) of Discharge from the Hospital: _____

9. Please tick as (√) specifying nature of claim as follows along with the Expense Details

Benefits	Per day Amount in Rs	No. of days hospitalised	Amount claimed
☐ 1a i) Sickness Hospital Cash			
☐ 1a ii) Sickness ICU Cash			
☐ 1b i) Accident Hospital Cash			
☐ 1b ii) Accident ICU Cash			
☐ 1c) Day Care Procedure Cash		NA	
☐ 1d) Joint Hospitalisation due to an accident			
☐ 1e) Convalescence			
☐ 1f) Child Birth		NA	
☐ 1g) Parent Accommodation			
Total Amount Claimed			

10. No. of Documents submitted including this Claim Form: _____

11. 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 hereby warrant that:

(1) I have read and understood General Conditions Section 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 in respect of that may apply to this claim.

Place and Date: _____

Signature of the Claimant / Insured: _____

Check List of Enclosures for Submission of Claim

- ☐ Duly filled and signed Claim Form
- ☐ Copy of current year Policy
- ☐ Copy of detailed Discharge Summary from the Hospital
- ☐ Copy of First Consultation letter and subsequent Prescriptions
- ☐ Copy of Investigation reports
- ☐ Copy of Hospital Bill
- ☐ Copy of Obstetric history (Living Children)

Customer Identification Procedure (as per KYC norms of IRDA)	
Please submit the following documents in case of claim amount exceeds Rs. 100,000	
Legal name and any other names used (Any one of the mentioned documents)	Passport/ PAN Card/ Voter's Identity Card/ Driving License/ Letter from a recognized public authority or public servant verifying the identity and residence of the customer
Proof of Residence (Any one of the mentioned documents)	Telephone bill/ Bank account statement/ Letter from any recognized public authority/ Electricity bill/ Ration card