# CEMer 1 FFR 2

## **HDFC ERGO General Insurance Company Limited**

Claim Form - my:health Critical Suraksha Plus



## CLAIM FORM – PART A TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability

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a)	Policy No.										b)	SI. N	o/ Ce	ertifica	te N	No:											(c)	) C	omp	any	TPA	ID	No.		$\perp$	$\Box$		$\Box$	$\perp$	$\perp$	$\perp$	$\perp$	
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a)	Currently o	overed by	any othe	er m	edicla	im h	nealth	insu	ırand	е	Ye	es		No						b)	Dat	e of	com	men	ceme	ent o	f firs	t in	surar	ice	witho	ut b	reak		D	D		M	M	,	YY	Y	Y
c)	If Yes, Com	npany Nam	е 📗																																		$\perp$	$\Box$			$\perp$		
	Policy No.														Su	m Ins	ure	d																									
d)	Have you b	een hospi	alized ir	the	last f	our y	years	sino	ce in	cepti	on of	the o	contr	act	Yes			No															Date		D	D		M	M	`	YY	Υ	Υ
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e)	Previously	covered by	any oth	ner I	Medicl	aim .	/ Hea	alth ir	nsur	ance					Yes			No																									
f)	If yes, Com	npany Nam	e																																$\perp$	$\perp$	$\perp$		$\perp$	$\perp$	$\perp$	$\perp$	
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j)	E-mail ID, i	f any																																		$\perp$	$\perp$		$\perp$	$\perp$	$\perp$	$\perp$	
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a)	Name of the	e Hospital	where a	dmi	tted																																						
b)	Room Cate	gory occu	oied				Da	ycare	е		Sin	gle C	)ccu	pancy			Twi	n Sha	aring	9 [	;	3 or	more	bed	ds pe	r roc	m																
c)	Hospitalisa	tion due to					Illn	ess			lnju	ıry					Mat	ernity	1																								
d)	Date of Inju	ury/ Date o	disease	e firs	st dete	ected	d/ Dat	te of	deliv	ery		D [		M M	Υ	/ Y	Υ	Υ			e)	Da	te of	adm	nissio	n [	D	D	М	М	Υ	Υ	Υ	Υ				f)	Time	е	Н	M	М
g)	Date of disc	charge	D D	N	M	Υ	Υ	Υ	Υ		h	) Tim	ne	Н	N	M																											
I)	If injury, giv	e cause	Self	-Infl	icted			Road	d Tra	ffic A	ccide	ent	[	S	ubs	tance	Ab	use			Alc	oho	l Con	sum	nptior	1																	
	I) If Medico	o legal	Yes		N	lo [						ii) F	Repo	rted to	ро	lice?		Yes		1	No [						iii)	ML	C Re	port	, & P	olic	e FIR	atta	ache	ad?	`	Yes		1	No [		
j)	System of r	medicine		Alle	opathi	С			Oth	er sy	/stem	s of	medi	icine																													
														SE	СТ	ION	Ε	- D	ET/	AIL	s c	)F	CL/	411	/																		
a)	Details of the	he treatme	nt exper	ises	claim	ned																																					
b)	Section und	der which o	claim is i	mad	е																																						
																Sec	tio	n A-	Ва	se	Cov	ers	;																				
	I - Critical Illness															II	II - Multi pay Critical Illness																										
	1) Cancer Cover															C	Cancer Cover														$\overline{}$												
	2) Heart Cover														Н	Heart Cover																											
	3) Nervous System Cover													N	Nervous System Cover																												
	4) Other Major Organs Cover														C	Other Major Organs Cover																											

													S	ection D : 0	Optiona	l Covers													
	1)	) Pre Diag	nosis	Cove	er																								
						Molecular Gene Expression Profiling Test																							
						ient Cou	ınselinç	9																					
	Second						d Medica	al Opin	ion																				
	3) Loss of Job Benefit																												
								Add on Covers										_ 1											
My:health Hospital Cash Benefit Add on																													
c) Please provide the details																													
,	1)			Pay	Critic	al IIIr	ness					Ple	ease m	ention the C	Critical III	ness claimed for:													
	ii)											Ple	ease m	ention the n	o of day	rs, benefit claimed	l for												
	иј површи одон																												
Claim Documents Submitted Check List:													.,																
		Duly filled and		ned (	Clain	n Fo	rm							of intimati		er, if any				cate confirming the diagnosis of Critical Illness m attending Medical Practitioner confirming the									
	Hospital Main Bill								riosp	ilai bili bie	ак ир					ness and need for surgery													
	☐ Hospital Bill Payment Receipt								ital Discha				First cor	sultatio	tion letter and subsequent prescriptions														
	Pharmacy Bill										ation theat					apers if applicable edico legal certificate(wherever applicable)													
	ECG     Investigation Reports confirming the diagnosis										ors reques criptions	t for inv	restigations		FIR cop	y or me	dico le	gal c	ertific	cate	(whei	ever	appl	icable)					
	(Including CT, MRI/USG/HPE)																												
Others																													
											SE	CTION	1 – F	DETAIL	S OF	BILLS ENC	LOS	SED											
S.	No	Bill No.			Da	-				ls	ssued	Ву				Towards	;				Amount (Rs)								
D D M M Y Y																													
																							+						
								S	SEC	TION	– G	DETA	ILS	OF PRIM	IARY	INSURED'S	ВА	NK ACCO	JNT										
a	) P.	AN													b)	Account Num	nber												
c)	) B	ank Name/ Brar	nch												d)	Payable deta	ails:	Cheque/ DD											
e	) IF	SC Code													e)	*please attac cheque perta													
f) MICR No						*please attach a cancelled cheque pertaining								ng to t	ne sa	me													
		s agreed that the																				deta	ils. I	In an	even	nt Ins	ured person		
bear	s exp	penses for treatr	nent	plea	se p	rovio	de a	CCOL	unt d	letails o	f Insu	red Per	rsons	in the abo	e form	at along with pr	oof	of incurring su	ch expe	enses.									
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of ar	ny ma essar	leclare that the in aterial fact with r y medical inform eipts for the purpo	espe ation	ct to	que cum	stior ents	ns as from	sked any	d in r y hos	elation spital/N	to this ledica	s claim, al Practi	my rig	ght to clain who has a	reimb ttended	ursement shall b I on the person a	be fo	orfeited. I also	conser	t & au	thoriz	e TF	PA/i	insura	ance	com	pany, to seek		
Date:         D D M M Y Y Y           Place:										Signature of Insured																			

### LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

#### Note:

- 1. When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organization/provider have to be submitted.
- 2. If original bills, receipts, prescriptions, reports and other documents are submitted to **Us** and Insured Person requires same for claiming from other organization/provider, then on request from the Insured Person **We** will provide attested copies of the bills and other documents submitted by the Insured Person.
- 3. If below mentioned documents are not provided in full or are insufficient for **Us** to consider the claim, then **We** may request additional information or documentation.

Documents for Critical Illnesses Cover, Multi pay Critic	cal Illness Cover										
☐ Claim Form duly signed by the Insured Person;											
☐ Copy of Discharge Summary / Discharge Certificate;	Copy of Discharge Summary / Discharge Certificate;										
☐ First consultation letter from treating Medical Practition	First consultation letter from treating Medical Practitioner										
$\hfill \Box$ Medical certificate confirming diagnosis, and the trea	Medical certificate confirming diagnosis, and the treatment from Medical Practitioner										
☐ Certificate from treating Medical Practitioner, specifyi	Certificate from treating Medical Practitioner, specifying the duration and etiology										
☐ OT Notes in case of Surgery	OT Notes in case of Surgery										
☐ Medical certificate from treating Medical Practitioner	Medical certificate from treating Medical Practitioner specifying the diagnosis and need for the surgery										
☐ MLC/FIR copy/ certificate regarding abuse of Alcohol	MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable										
All pathological and radiological Investigation Report	All pathological and radiological Investigation Reports										
☐ NEFT details & cancelled cheque	NEFT details & cancelled cheque										
Provide KYC (Know your customer) form along with (Passport, Driving Licence, Voter ID, etc)	Provide KYC (Know your customer) form along with photocopy of any one of following KYC documents for all claims amounting to Rs 1 lakh and above (Passport, Driving Licence, Voter ID, etc)										
Documents and process for Second Expert medical O	pinion										
<ul> <li>Duly filled claim form along with the copy of all medica</li> </ul>	•	eports and discharge summary (	if any)Consultation fees payment Receipt / invoice								
CUSTO	MER IDENTIFICATION P	ROCEDURE (AS PER K	YC NORMS OF IRDAI)								
Please submit the following documents in case of claim an	nount exceeds Rs. 100,000										
Legal name and any other names used(Any one of the me	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 accou Electricity bill/ Ration card	unt statement/ Letter from any recognized public authority/								
Claim Form –Loss of Job Please mention the type of Loss of Job											
Type of loss of Job	Details along with Reason		Date								
Termination	mination										
Dismissal / temporary suspension											
Retrenchment Earlier E											
Resignation											
Documents for loss of Job											
☐ Duly Completed Claim Form signed by Insured Person;											
☐ Form 16A	Form 16A										
☐ Termination letter/Resignation Letter/Resignation Accept	ance letter										
NEFT details & cancelled cheque											