



GROUP MEDICLAIM INSURANCE

INSURED'S INFORMATION

Name of Policyholder:
 Policy No.: Certificate No.: (If applicable)

CLAIMANT INFORMATION

Name of Patient:
 Occupation: Date of Birth: Present completed age:
 Address and phone number:
 Relationship to the Policyholder: Member/ Employee Spouse Dependent Child Dependent Mother Dependent Father

1. Nature of sickness/ diseases/ injury claimed for:

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

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:

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:

6. Details of hospitalisation:

Name of Hospital/ Nursing Home:

Address:

Date of Admission: Date of Discharge:

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.

I/We hereby understand, declare, consent and authorise the Company that personal health details, medical history and financial information, as provided to the Company may be utilised for processing the claim made under the Policy. I/We hereby also understand, declare and consent that the Company shall have right to retain and disseminate the same to any service provider for providing services related to insurance.

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 photocopy or facsimile copy of this authorisation shall be as valid as the original.

Date:
 Place:

Signature of Patient

HDFC ERGO General Insurance Company Limited



Consent for Mode of Claim Payment

Name of Insured

Policy Number

Claim Number

Beneficiary Name

Mode of Payment Cheque Fund Transfer

(Please tick for mode of payment)

(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 Canceled Cheque Bank Passbook Copy
(Please tick the type of proof submitted)

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: