

HEALTH CLAIM FORM

(The issuance of this form is not be taken as an admission liability - Please give the following information correctly and completely)

Part A (To be filled by Insured) (To be filled in BLOCK LETTERS)			
			Pre Authorization obtained Yes / No
1. Type of Claim:	<input type="radio"/> Hospitalization	<input type="radio"/> Pre & Post Hospitalization	<input type="radio"/> Health Check up <input type="radio"/> OPD
2. *Policy No.	Policy Type: <input type="radio"/> Individual <input type="radio"/> Group		
Group/Company Name (for Group Health Policies)			
Is this a renewal policy	<input type="radio"/> Yes <input type="radio"/> No	If Yes, previous year's policy no xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	
Agent/Sub Agent Name			
Agent Mobile No.		Agent Email ID	
3. Details of the Insured Person in respect of whom the claim is made			
*Name			
Present completed age (in years)		Gender: <input type="radio"/> M <input type="radio"/> F	
Relationship with the Policy Holder			
*Card / UHID No.		Sum Insured ₹	
*Current Residential Address			
City		*PIN Code	State
Change of the contact Details	<input type="radio"/> Yes, I wish to change my contact details <input type="radio"/> There is no change in my contact details		
Please update mentioned mobile number as primary contact details against my policy. I also hereby confirm to be contacted on the number provided below for Claim Status /Policy Renewal.			
*Mobile Number			
4. Profession/Occupation	<input type="radio"/> Business	<input type="radio"/> Profession	<input type="radio"/> Salary <input type="radio"/> Agricultural Income <input type="radio"/> Savings <input type="radio"/> Others
5. Monthly Income	<input type="radio"/> Upto ₹ 20,000 <input type="radio"/> ₹ 20,001 to ₹ 50,000 <input type="radio"/> ₹ 50,001 to ₹ 1,00,000 <input type="radio"/> ₹ 1,00,001 and above		
6. PAN No.			
7. Name of the Policy Holder (Self / Main Member)			
*Email ID			
Member ID No. / Employee ID / Client ID			
8. Does the claimant have health insurance policy with any other insurance company?		Yes / No (If yes, please provide the details)	
Name of the Insurance Company			
Policy No.		Sum Insured ₹	
Policy Start Date DD/MM/YYYY		Policy End Date DD/MM/YYYY	

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IRDAI Registration No. 103. IndusInd General Insurance Company Limited (Formerly known as Reliance General Insurance). An ISO 9001:2015 Certified Company For complete details on the benefits, coverage, terms & conditions and exclusions, do read the sales brochure, prospectus and policy wordings carefully before concluding sale. Registered & Corporate Office: 6th Floor, Oberoi Commerz, International Business Park, Oberoi Garden City, Off. Western Express Highway, Goregaon (E), Mumbai-400063. Corporate Identity Number: U66603MH2000PLC128300. IndusInd Health Care. IGI/MCOM/CO/COMMON-HEALTH CLAIM FORM/Ver. 1.8/170220.

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Name of the Insured					
9. Hospitalization Detail -	DD/MM/YYYY				
Date of Admission	DD/MM/YYYY				
Date of Discharge	DD/MM/YYYY				
Diagnosis / Nature of disease / illness contracted / injury suffered					
10. Date of injury sustained or disease / illness first detected					
11. Details of the Hospital / Nursing Home in which treatment was taken :					
Name of the Hospital / Nursing Home					
Address of the Hospital / Nursing Home					
City	PIN Code				
Telephone / Mobile Number	Registration Number				
12. Name of Treating Physician / Surgeon					
Qualification	Registration Number				
Telephone / Mobile Number	Email ID				
13. Details of the amount claimed					
	Bill Heads	Amount / (In ₹)	Bill number	Bill Date	Bills attached (Yes/No.)
A	Room Rent & Nursing Charges				
B	Doctors Consultation/ Visit Charges				
C	Investigation Charges(Includes Radiology and Pathology Reports)				
D	Surgeon and Asst. Surgeon Charges				
E	Anesthetist Charges				
F	Operation Theater Charges				
G	Medicine Charges (Includes Ward and OT Medicines and Consumables)				
H	Taxes/Surcharges/ Service Charge				



I	Miscellaneous/ Other Charges (like Admission, Registration, etc.)			
J	Pre Hospitalization Bills (If Any)			
K	Post Hospitalization Bills (If Any)			
Total Claimed Amount (Sum of A to K)				

In support of the above claim, I enclose following documents in original (Please indicate by ticking the Yes / No)

Claim form Duly Filled	Yes / No	Investigation Reports/Reports Name	Yes / No
Authorization Form	Yes / No	Medicine/Pharmacy Bills with Doctors Prescription	Yes / No
Discharge Summary	Yes / No	Implant Name and Invoice (If any)	Yes / No
Hospital Bills	Yes / No	Indoor Case Papers (duplicate copy)	Yes / No
Hospital Payment Receipt	Yes / No	Others	Yes / No
Photo Identity Proof	Yes / No		
Total No. of Pages enclosed			

As per the policy terms and conditions, the Company reserves its right to have the Insured examined by a doctor appointed by it for verification of diagnosis.

Please note: In case the Health Gain Policy under which the claims is being lodged has been taken on instalment basis then in the event of claim being admissible, the company will deduct the balance instalments due if any, from the claim approved amount and pay the balance due to the Policyholder. In the event of the claim assessed amount being lower than the Balance instalment due then the Policyholder is liable to pay the balance premium instalments due immediately by cheque or DD, failing which the said Claim would be treated as inadmissible and the Policy shall stand cancelled immediately and no liability shall be admissible under the Policy for any Claims liability in future or in period elapsed.

Any hospitalization from the notified Hospital will not be entertained. please refer the notified hospital list on our website: www.indusindinsurance.com

Policyholder Bank Details

14. Name of the Bank Account Holder Mr. Mrs. Ms.: FIRST MIDDLE LAST

15. Bank Account No.: 16. Account: Saving Current

17. Name of the Bank

18. Branch

19. MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)

20. IFSC Code (11 character code appearing on your cheque leaf)

I understand that any refund due on the premium payment / any payment / claims to be directly credited to my aforesaid Bank Account.*



*As per IRDAI, its mandatory that all payments made to the insured are only through electronic mode.

Note: Please attach original cancelled cheque and a copy of PAN card for verification of the particulars provided in this regard.

Payment Option by Aadhaar Card (For Reimbursement claims)

Aadhaar Card No.: _____ (Note: Self attested Aadhaar card copy to be submitted)

I wish to collect claim reimbursement directly in my Bank account linked with my aforementioned Aadhaar Card. I understand that the claim amount shall be credited directly in my latest Bank account linked with my Aadhaar Card.

I/We hereby declare that the details given above are true and correct to the best of my belief and knowledge. In the event above information or any part thereof is found incorrect, I agree that all right under the policy will be forfeited. I agree to provide additional information to the Company if required. I will indemnify and hold harmless the Company due to any loss arising out of misstatement in this form and am willing if required, to make a statutory Declaration before a Justice of the Peace of the truth of the whole of the foregoing statement or any other statement I may make in connection with this claim.

I further agree and undertake not to receive from IndusInd General Insurance Company Limited any rebate other than that mentioned in the published prospectus in accordance with the provisions Section 41 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015.

Place: _____

Date: DD/MM/YYYY

(Signature of Claimant)

Part B - To be filled by the Treating Doctor (This section is mandatory only if your health policy was not provided by your employer)

A) Date of First Consultation (Prior to Hospitalization)

B) With what complaints was the patient admitted for

C) Detail history of past illness with duration

Date: DD/MM/YYYY

D) Whether the present ailment is a complications of Pre-Existing disease ?

E) If, yes please specify the disease (OR) complication of any previous surgery done ?

F) Whether the disease / disorder is congenital in nature ?

G) If yes please specify the details

H) Nature of surgery / treatment given for present ailment

(Doctor's Seal and Signature)

I) Number of in-patient beds in the hospital (including ICU)

Terms and Conditions for Payments through RTGS/NEFT

1. The details provided by the Customers in the Mandate form shall be considered as final and IndusInd General Insurance Company Ltd. Shall not be responsible for cross verification of any of the details provided therein.
2. The RTGS/NEFT facility shall be effective for the respective customer(s) within 15 days of the receipt of the Mandate form by IndusInd General Insurance Company Ltd. and/or within such period as may be reasonably required by IndusInd General Insurance Company Ltd. to activate the RTGS/NEFT facility.
3. The Customer agrees that under the RTGS/NEFT facility, there may be a risk of non-payment in the account of customer on the day of the credit of payments due to change in the applicable regulations pertaining to RTGS/NEFT facility or due to any other reasons without any fault/inaction/failure on part of IndusInd General Insurance Company Ltd or any factor beyond the control of IndusInd General Insurance Company Ltd.

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4. The customer agrees to indemnify, without delay or demur, IndusInd General Insurance Company Ltd and its agents and keep IndusInd General Insurance Company Ltd and its agent indemnified harmless at all times from and against any and all claims, damages, losses, costs, and expenses (including attorney's fees) which IndusInd General Insurance Company Ltd may suffer or incur, directly or indirectly, arising from or in connection with, amongst other things, either of the aforesaid reasons stated in above clauses.
5. The Customer May discontinue or terminate the use of RTGS/NEFT facility by giving a minimum of 15 days prior written notice to IndusInd General Insurance Company Ltd. The date of notice will be considered from the date of receipt of such notice by IndusInd General Insurance Company Ltd. The notice of, such termination should be given to IndusInd General Insurance Company Ltd. only at its corporate address and be addressed at IndusInd General Insurance Company Limited, IndusInd Centre, South Wing, 4th Floor, Off. Western Express Highway, Santacruz (East), Mumbai - 400 055.
6. A Confirmation of the receipt of termination notice given by the customer will be acknowledge through a confirmation Letter by IndusInd General Insurance Company Ltd. In no case can be the customer construe his termination notice as effective unless a confirmation has been provided by IndusInd General Insurance to the customer stating the date of Receipt of such communication by the customer.
7. The Customer agrees that transaction(s) through RTGS/NEFT may attract inward RTGS/NEFT charges, which if levied by the customer's bank, shall be borne by the customer.
8. IndusInd General Insurance has the absolute discretion to amend or supplement any Terms and Condition stated herein at any time and will endeavor to give prior notice of Ten days for such changes wherever feasible for the terms and conditions to be applicable. By using the new services, or at the completion of such period, whichever is earlier, the Customer shall be deemed to have accepted the changed terms and conditions.
9. NEFT facility for group policy holder shall be done at the consent of HR.
10. Notices under these terms and conditions may be given in writing by delivering them by hand or e-mail or on IndusInd General Insurance Company Ltd. website www.indusindinsurance.com or by sending them by post to the last address of the Customer.
11. These terms and conditions will be governed by the laws of India and any legal action or proceedings arising out of these Terms and Conditions shall be initiated in the courts or tribunals at Mumbai in India.
12. I/We further undertake to refund any excess amount whether demanded by IndusInd General Insurance Company Limited or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from IndusInd General Insurance of such excess credit or such information of excess credit coming to the knowledge of the customer through any other source.
13. I/We agree that my/our claim payment will be credited from the date IndusInd General Insurance Company Ltd. gets confirmation from its bankers, this facility will continue unless it is revoked by any party and any issuance of relevant credit instruction from IndusInd General Insurance Company Ltd. to its bankers will be valid till such instructions is complete irrespective of the fact that the notice period has expired provided such a credit request has been made by IndusInd General Insurance Company Ltd. before the expiry if the notice period of the customer.
14. As per IRDAI any claimed amount above 1 lac, Copy of PAN Card/Form 60 of the insured for corporate reimbursement claim/Proposer for retail reimbursement claim is mandatory, and below 1lac Photo identity proof (for eg- Aadhar card, Driving license, Election card, Passport etc) is mandatory.
15. For NEFT settlements to insured/Proposer we require CTS 2010 cheque, CTS 2010 compliant cancelled cheque should have Name of the Account holder, Account number and IFSC code of the bank to be printed on cheque is mandatory
16. Incase of Non CTS 2010 compliant cheque photocopy of the passbook/bank statement with all the required details (Name of the Account holder, Account number and IFSC code of the bank should be printed on passbook/bank statement) should be submitted.

(Signature of the account holder)

* Mandatory details to be filled



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