Health Claim Form

AEGON RELIGARE LIFE INSURANCE

IMPORTANT NOTE:

SECTION I & II OF THIS FORM IS TO BE COMPLETED BY THE INSURED/CLAIMANT. SECTION II IS ALSO TO BE DULY VERIFIED AND ATTESTED BY THE TREATING PHYSICIAN AND/OR BY THE HOSPITAL AUTHORITIES WHERE THE INSURED WAS UNDER TREATMENT FOR THE AILMENT IN CONNECTION WITH THIS CLAIM.

For Multiple Hospitalisation, separate forms have to be used for each Hospital Admission Session.

The issue of this form is not to be taken as an admission of liability by the Company under your Policy.

SECTION I

1. Details of benefits claimed (Please tick whichever is appropriate/applicable to the claim being made)

[ ] Daily Hospital Cash Benefit [ ] Intensive Care Benefit [ ] Surgical Cash Benefit [ ] Other Surgical Benefit

[ ] Critical Illness Benefit [ ] Others, (Please Specify): _____

2. Policy No.: _____ Customer ID.: _____

3. Proposer (Policyholder/Claimant): _____

Address of Proposer: _____

_____ Pin Code: _____

Phone No. (With STD code): _____ Mobile No.: _____

E-mail ID, if any: _____

4. Name of the Insured Person hospitalised: _____

Relationship with Policyholder: _____

Customer ID: _____

Date of Birth: _____ (dd/mm/yyyy) Age: _____ Years _____ Months

Gender: Male / Female: Occupation: _____

5. Name of Family Doctor: _____ Contact Details: _____

6. Past History:-

a) Have you been hospitalised in the past: ☐ Yes ☐ No

b) If yes, diagnosis: _____ Month & Year of diagnosis: _____ (Month) _____ (Year)

c) Name and Address of the Hospital: _____

7. Type of Admission (please tick whichever is appropriate): [ ] Emergency [ ] Planned [ ] Daycare

8. Do you have Mediclaim / Health Insurance Policy with any other insurance company? ☐ Yes ☐ No

If yes, give details

a) Name of Insurance Company: _____

b) Policy No: _____

c) Policy Term: _____

d) Name of the Insured: _____

e) Whether any claim has been lodged with any such insurance company in connection with the disease of the insured for which the present claim has been made to AEGON Religare? ☐ Yes ☐ No

SECTION II

9. Hospital / Medical Service Provider Details:

a) Name of the Hospital where treated: _____

b) Address of the Hospital: _____

_____ Pin Code : _____

c) Phone Number of the Hospital (with STD Code): _____

d) Hospital Registration Number: _____ e) No. of Inpatient Beds: _____

f) Other facilities available in Hospital:

i) OT : ☐ Yes ☐ No ii) ICU : ☐ Yes ☐ No

iii) Others (Please Specify): _____

10. Admission Details:-

a) Date of Admission: _____ b) Time of Admission: ____ : ____ AM/PM

c) Date of Discharge: _____ d) Time of Discharge: ____ : ____ AM/PM

e) Date of Commencement of ICU Treatment: _____ f) Time of Admission in ICU: ____ : ____ AM/PM

g) Date of Completion of ICU Treatment: _____ h)Time of Discharge from ICU: ____ : ____ AM/PM

11. Ailment Details (as diagnosed):-

a) Nature of Disease / Ailment (diagnosed): _____

b) Date of Disease / Illness first detected: _____

c) Symptoms: _____ d) Duration of Symptoms: _____

e) Whether the present disease/illness/Injury is a complication of any disease/ illness/ injury suffered in the past. ☐ Yes ☐ No

If yes, provide details and specify since when: _____

f) Name of Surgery(s) undergone (If done): _____

g) Date of Surgery(s) : _____

12.Is this treatment for any injury:- ☐ Yes ☐ No Date of Injury sustained: _____

If yes, give details

a) Was it self inflicted: ☐ Yes ☐ No

b) Whether RTA(Road Traffic Accident): ☐ Yes ☐ No

c) Was it notified to police (Medico-Legal Case) by you/your relatives/ hospital? ☐ Yes ☐ No

d) MLC No:/FIR No: _____

e) If FIR is not filed, give reasons: _____

13. Treating Doctor Details:-

a) Name of the Treating Doctor: _____

b) Registration Number of the Doctor with state code: _____

c) Qualifications : _____ d) Mobile Number: _____

DECLARATION BY THE INSURED

I hereby declare that the information furnished in this Form is true, complete and correct and nothing has been withheld or suppressed. I understand and agree that if any information furnished/statements made in this Form is found to be untrue, or if it is found that I have suppressed or concealed or withheld any fact/s while furnishing the details or replying to the questions in this form or if any of the

documents submitted is found to be tampered with or is not genuine, then, subject to any other remedy AEGON Religare Life Insurance Co mpany (ARLIC) may have in respect of this claim, the claim made by me herein is liable to be repudiated by ARLIC solely on that ground and if any of the documents submitted by me are found to be tampered with or are not genuine, ARLIC may also , in it's sole discretion, declare the policy null and void. I hereby authorise the representative of TPA, M/s Paramount Health Services (TPA) Pvt. Ltd. ("TPA") and AEGON Religare Life Insurance Company (ARLIC) and its authorised representative free and unlimited access to seek medical information (Indoor case papers, reports, documents, including photocopies thereof/pertaining to the insured's admission/treatment etc.,) from any hospital/medical practitioner from which the Insured member has at any time sought or availed of medical attention concerning any disease/sickness, ailment or injury, which affects or may affect the physical or mental health of the insured.
I also hereby authorise the hospital/attending doctor/medical practitioner from whom the Insured member has sought or availed of any medical attention/medical treatment concerning any disease/sickness, ailment or injury which has affected the Insured member's physical/mental health, to share the above information and make available the records relating to such medical attention /medical treatment to the TPA/ ARLIC or their authorised representative/s treating them as the " authorised attendant" under regulation 1.3.2 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations,2002. I /my successors/assigns shall not raise any dispute or litigation on passing of such information to the TPA or ARLIC or its authorised representatives.

Name of the Policyholder: _____

Signature of the Policyholder: _____

Date: | | | | | | | | |

Place: _____

(Insured's Photo ID – With Hospital Attestation)

DECLARATION BY THE HOSPITAL

We hereby declare & confirm that the information furnished in Section II of this claim form is true & correct.

Name & Seal of the Hospital: _____

Authorised Signatory of the Hospital: _____

Date: | | | | | | | | |

Place: _____

NOTE: Please submit this "Claim Form" with all the enclosures to your TPA. The claim form along with the "Claim Discharge Form" should be submitted collectively to enable claim processing.

Claim Documents Checklist (Please tick (✓) whichever is appropriate/applicable to the claim being made):

a)	Duly filled & signed Claim Form	☐ Yes	☐ No
b)	Attested true copies of Indoor Case Papers of the Hospital	☐ Yes	☐ No
c)	Discharge Summary of Present & Past (if applicable) Hospitalisation	☐ Yes	☐ No
d)	Summary of procedure in case of Daycare treatment	☐ Yes	☐ No
e)	Hospital Main Bill*/ Hospital Break-up Bills*	☐ Yes	☐ No
f)	Cash memos from Doctor, Chemist, Diagnostic Centres/Hospitals	☐ Yes	☐ No
g)	Investigation Reports/ Reports Name	☐ Yes	☐ No
h)	First consultation papers, OPD papers, medicine details	☐ Yes	☐ No
i)	Implant Name, sticker/ invoice (if any)	☐ Yes	☐ No
j)	Police FIR/ MLC copy (In case of Injury or accident ,if applicable)	☐ Yes	☐ No
k)	Death Certificate (if applicable)	☐ Yes	☐ No
l)	Others (if any)	☐ Yes	☐ No
m)	Total No. of pages enclosed		

Note:

1. Copies of the bills duly attested by Hospital Authorities would suffice. Bills once submitted will NOT be returned
2. If treatment/medical attention has been received from more than one hospital, please attach copiesof the Discharge/Discharge Cards of all such hospitals
3. The Company reserves the right to seek additional information/document to process the claim

Discharge Form - Without Prejudice (To filled in by the Policyholder)

(The issue of this form is not to be taken as an admission of liability)

Name of the Policyholder (Claimant): _____

Address of the Policyholder: _____

_____

Policy No: | | | | | | | | | | | | | | | | Name of the Primary Insured: _____

I hereby authorise AEGON Religare Life Insurance Company Ltd. to process the above claim as per Terms & Conditions and limitations of the captioned Policy. This discharge is delivered in full and final settlement of the hospital bills and laboratory investigation bills submitted by me and is to the full satisfaction of my above mentioned claim.

Preferred Payment Mode: ☐ Cheque ☐ NEFT

Details of the bank A/C of the Policyholder:

a) Beneficiary Name (as in bank records): _____
b) Beneficiary's Bank Name: _____
c) Beneficiary's Bank Account Number: _____
d) Account Type: _____
e) IFSC Code.: _____
f) Email ID of Beneficiary: _____

(Please attach a cancelled cheque leaf to authenticate the details given)

The details of Bank account and address of the bank etc. furnished by me above are correct. I declare that the above payment is in discharge of full and final benefit amount as may be applicable under the policy terms irrespective of if the claim amount should exceed the actual benefit amount.

Place: _____ Date: | | | | | | | | |

Name: _____

Signature of the Policyholder (Claimant) _____

(To be signed across the Revenue Stamp):

REVENUE STAMP