CLAIM FORM

How to file a Claim

- In case of any event leading to a claim under the policy, please call our Toll-free number 1600-226-226
- Our Claims Service Representative will guide you on the claim procedures and documents required.
- A claim form will be forwarded to you by mail, email or fax.
- Complete the claim form relevant to the nature of loss as indicated below.
- Attach the documents mentioned against the claim type.

For Accidental Injury Claims	1. Claim form 2. Police Report, if accident is reported to Police 3. Medical papers, pathology reports, X-ray reports, as applicable 4. Doctor's medical prescriptions, Itemized bills and cash memos* 5. Hospital Discharge Card
For Hospitalisation due to Illness/Disease	1. Claim Form 2. Medical papers, pathology reports, X-ray reports, as applicable 3. Doctor's prescription and line of treatment suggested 4. Itemized bills and cash memos* 5. Hospital Discharge Card

***Copies of fully itemized medical bills. Itemized bills must show the patient's name, date of treatment, the type of treatment given, the diagnosis or nature of condition being treated and the Hospital/Nursing Home's name and address.

- Documents, in addition to those mentioned above maybe called for, depending on the nature of claim lodged.
- You may also send the claim form with Annexure to our Claims Processing Cell at the following address:

  Claims Department
  HDFC CHUBB General Insurance Company Limited
  5th Floor, Express Towers, Nariman Point
  Mumbai- 400 021

  - Please retain a copy of the documents sent for your records.

(N.B. To be filled in by the Insured, or Insured's Authorised representative enjoying power of attorney.

- Issuance of this claim form is not be taken as admission of liability under the policy on the part of the insurer)

PART I – Insured's Information

Name of Policyholder:
Name of Member / Employee of Insured Family :
Policy No. _____ Membership / Employee No.:_____ Certificate No. _____ (If applicable)

PART II – Claimant Information

Name of Patient:	I.D. Card No.:
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 /disease/injury claimed for : _____ Date on which Injury was sustained or disease or illness first detected : _____ Date of first consultation : _____ Name, Address, Telephone No. of Doctor Consulted : _____ Qualification of the Doctor Consulted :_____	
(2) Have you had any prior treatment for this or related conditions? NO ( ) YES ( ) Doctor's Name : Qualification : Address & Telephone: Date(s) :	
(3) Are you making any other insurance claim as a result of this hospitalization/surgery? NO ( ) YES Name of Insurance Company : Policy No. :	
(4) Was the hospitalization/surgery a result of an accident? NO (YES (Place of Accident _____ Date of Accident _____	
(5) Is the claim is for Maternity Expense Benefit: NO (YES (If so, is it your (first delivery (second delivery (third delivery Are you already having 2 children: NO (YES (	
(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 (Rs)
		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

AUTHORISATION

I HEREBY AUTHORISE on behalf of the patient: (1) Any employer, 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 Chubb General Insurance Company; (2) HDFC Chubb 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: Signature of Patient
Place:

This is to certify that the above-mentioned claim lodged by the Insured / Claimant is genuine and the same is recommended for reimbursement.

Authorised Signatory **Place:**
Name of the Policyholder & Seal: **Date:**

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician: _____ Phone No. _____

Address:

_____

I certify that the above named patient _____, was seen by me on _____ and has been fully cured of the sickness/injury claimed for, which first incurred on _____

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Attending Physician) _____

DATE ____/____/____