

**CLAIM FORM**

Issuance of this form does not amount to admission of any liability or a waiver of any of the terms and conditions of the Policy. If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or any Insured Person or anyone acting on behalf of You or an Insured Person, then the Policy shall be void and all benefits paid under it shall be forfeited.

Please give the following information correctly and completely to enable us to process Your claim promptly. We may call for additional documents/information as required. Use additional sheet, if required.

**A) Details of the Policy / Insured Person**

Policy Number (in full) \_\_\_\_\_ Certificate Number \_\_\_\_\_  
 Policy Period: Policy Commencement Date (DDMMYYYY) \_\_\_\_\_ Policy Expiry Date (DDMMYYYY) \_\_\_\_\_  
 Name of Policyholder \_\_\_\_\_ Name of the Insured Person \_\_\_\_\_  
 Date of Birth (DDMMYYYY) \_\_\_\_\_ Gender: Male  Female  Occupation \_\_\_\_\_  
 Permanent Address in India \_\_\_\_\_  
 Address proof: Passport copy  Electricity bill  Telephone bill  Driving license  If other, please specify \_\_\_\_\_  
 Telephone \_\_\_\_\_ Mobile \_\_\_\_\_ Email-ID \_\_\_\_\_

**B) Details of the Claimant (if different than the Insured Person)**

Name \_\_\_\_\_ Date of Birth (DDMMYYYY) \_\_\_\_\_ Gender: Male  / Female   
 Permanent Address \_\_\_\_\_  
 Relationship to the Policyholder / Insured Person \_\_\_\_\_  
 Telephone (in India) \_\_\_\_\_ Mobile (in India) \_\_\_\_\_ Email-ID \_\_\_\_\_

**C) Details of the Claim**

Please tick the applicable benefit You want to claim:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Personal Accident                | <input type="checkbox"/> Medical Evacuation          | <input type="checkbox"/> Transportation of Mortal Remains |
| <input type="checkbox"/> Personal Accident - Carrier      | <input type="checkbox"/> Delay of Checked-in Baggage | <input type="checkbox"/> Trip Curtailment                 |
| <input type="checkbox"/> Medical Treatment                | <input type="checkbox"/> Emergency Travel            | <input type="checkbox"/> Personal Liability               |
| <input type="checkbox"/> Total Loss of Checked-in Baggage | <input type="checkbox"/> Trip Delay                  | <input type="checkbox"/> Trip Cancellation                |
| <input type="checkbox"/> Flight Delay                     | <input type="checkbox"/> Emergency Hotel             |   |

**D) Medical Treatment**

Please attach Medical Practitioner's reports, original admission / discharge card, original bills / receipts with prescriptions and diagnostic / investigative reports and copy of the ticket, boarding pass & address proof.

In case of an accident, please provide details, i.e. how, when and where it took place.

\_\_\_\_\_

Dates of treatment: Start \_\_\_\_\_ End \_\_\_\_\_ Date of admission \_\_\_\_\_ Date of discharge \_\_\_\_\_

Nature of Disease / Nature of Injury (Please describe briefly) \_\_\_\_\_

Name, Address and Contact Number of Treating Medical Practitioner / Physician / Dentist / Clinic or Hospital:

\_\_\_\_\_

Please enclose Police Report, if available.

Sr. No.	Expense Details	Issued by	Amount	Amount of received compensation	Remarks
		TOTAL			

**E) Medical Evacuation / Transportation of Mortal Remains**

Please attach Medical Practitioner's reports, original admission / discharge card, original bills / receipts with prescriptions and diagnostic / investigative reports and copy of the ticket, boarding pass & address proof.

Name, Address and Contact Number of Treating Medical Practitioner / Physician / Dentist / Clinic or Hospital:

Name of the disease contracted \_\_\_\_\_  
 When disease first manifested (Date) \_\_\_\_\_ Dates of treatment: Start \_\_\_\_\_ End \_\_\_\_\_  
 Date of admission \_\_\_\_\_ Date of discharge \_\_\_\_\_  
 Nature of Disease / Injury (Please describe briefly) \_\_\_\_\_

Reason for Medical Evacuation \_\_\_\_\_

Date of Evacuation: \_\_\_\_\_

Date of Death (DDMMYYYY) \_\_\_\_\_ Cause of Death \_\_\_\_\_

Please attach the official death certificate and a physician's statement for cause of death.

In case of an accident, please provide details, i.e. how, when and where it took place.

Please enclose Police Report, if available.

Also, please provide – if applicable – name of Carrier, burial details with bifurcation of incurred Expenses.

Sr. No.	Expense Details	Issued by	Amount (Rs.)	Amount of received compensation	Remarks
		TOTAL			

**F) Loss or Delay of Checked-in Baggage**

Please attach the original invoice & receipts with the details of individual items purchased during the delay period / individual items lost, cost and purchase date, copies of baggage tags, copies of correspondence with Carrier authorities / others about loss / delay of checked baggage, along with details of compensation received from Carrier / other authorities (if any), Property Irregularity Report (obtained from Carrier), Adequate proof of ownership of items contained within checked-in-baggage valued in excess of INR 2000 & address proof.

Name of the Carrier \_\_\_\_\_ Carrier Number \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
 Scheduled Departure Date and Time \_\_\_\_\_ Scheduled Arrival Date and Time \_\_\_\_\_  
 Actual Departure Date and Time \_\_\_\_\_ Actual Arrival Date and Time \_\_\_\_\_  
 Date and Location of loss \_\_\_\_\_ Date and time of Checked-in Baggage retrieval \_\_\_\_\_  
 Number of Checked-in Baggage \_\_\_\_\_

Expense / Loss Details	Date	Place	Amount (Rs.)
Amount refunded by Carrier		TOTAL	

**G) Personal Liability / Personal Accident**

Please attach Police Report, Post Mortem Report (in case of death), Official Death Certificate (in case of death), Medical Report in the enclosed format, Certificate from treating Medical Practitioner for Permanent Disability, original photograph of the injured reflecting disablement, Succession Certificate (in case of death of insured), Judgment of the Court for Personal Liability & address proof.

Date and Time of Accident \_\_\_\_\_ Place of Accident \_\_\_\_\_  
 Full description of the cause of Accident \_\_\_\_\_

Name, Address and Contact Number of Treating Medical Practitioner / Physician / Dentist / Clinic or Hospital:

Nature of Claim being made \_\_\_\_\_ Court where the case is being pursued \_\_\_\_\_

\* For Personal Accident, we shall provide a separate claim form up on notification

**H) Flight Delay / Trip Delay / Trip Cancellation and Curtailment**

Please attach any detailed report / confirmation from the Carrier / Hospital / Police / others of incident which leads to the delay / cancellation / curtailment of the flight / trip, copies of correspondence with Carrier authorities / others about delay / cancellation / curtailment, along with details of compensation received from Carrier / other authorities (if any), original admission / discharge card, diagnostic / investigative reports of hospitalisation, official death certificate, invoices & receipts, Proof of Loss & address proof.

Name of the Carrier \_\_\_\_\_ Carrier Number \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
 Scheduled Departure Date and Time \_\_\_\_\_ Scheduled Arrival Date and Time \_\_\_\_\_  
 Name of the Carrier \_\_\_\_\_ Carrier Number \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
 Actual Departure Date and Time \_\_\_\_\_ Actual Arrival Date and time \_\_\_\_\_  
 Cause of Incident (Flight Delay / Trip Delay / Trip Cancellation and Interruption) \_\_\_\_\_

Description of incident \_\_\_\_\_

Expense / Loss Details	Date	Place	Amount (Rs.)
Amount refunded by Carrier		TOTAL	

**I) Emergency Travel and Hotel**

Please attach Medical Practitioner's reports, original admission / discharge card, diagnostic / investigative reports, and copy of the ticket and boarding pass, invoices / receipts & address proof.

Address and Contact Number of Treating Medical Practitioner / Physician / Dentist / Clinic or Hospital: \_\_\_\_\_

Date of admission \_\_\_\_\_ Date of discharge \_\_\_\_\_  
 Nature of Injury (Please describe briefly) \_\_\_\_\_

Relationship to the Insured Person \_\_\_\_\_

Details of Expenses	Date	Place	Amount (Rs.)
Amount refunded by Carrier & hotel		TOTAL	

**J) Declaration**

I, the undersigned, authorise any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organisation, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to Apollo DKV or its representatives, any and all information with respect to any injury or illness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, illness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, including to determine eligibility for benefit payments under the Policy Number identified above. I understand that this authorisation is valid for the term of coverage of the Policy identified above and that a copy of this authorisation shall be considered as valid as the original. I understand that I or my authorised representative may request a copy of this authorisation.

I hereby declare and warrant that:

- (1) I have read and understood the terms, conditions and exclusions of this Policy, and
- (2) that the foregoing particulars are true and complete in all material respects, and
- (3) there is no other insurance in force that may apply to this claim.

Signature \_\_\_\_\_

Date and Place \_\_\_\_\_

**K) Medical Report (to be filled by treating Medical Practitioner )**Patient's Name \_\_\_\_\_  
Date of Birth (DDMMYYYY) \_\_\_\_\_ Gender: Male  / Female Patient's Address \_\_\_\_\_  
\_\_\_\_\_Date and Time of first consultation \_\_\_\_\_  
Dates of treatment: Start \_\_\_\_\_ End \_\_\_\_\_  
Date of admission \_\_\_\_\_ Date of discharge \_\_\_\_\_  
Nature of complaints \_\_\_\_\_Diagnosis \_\_\_\_\_  
Treatment given \_\_\_\_\_History of presented complaints \_\_\_\_\_  
\_\_\_\_\_Is the present condition due to pregnancy? Yes  No  If yes, provide details \_\_\_\_\_Is the present condition due to any pre-existing condition? Yes  No  If yes, provide details \_\_\_\_\_

Please provide history of any disease, accident or hospitalisation with details and duration \_\_\_\_\_

Date and Time of the accident \_\_\_\_\_

Are the injuries suffered solely due to the accident? Yes  No  If no, provide details \_\_\_\_\_Was the patient under influence of alcohol / drugs at the time of the accident? Yes  No Is the injured person totally disabled from each and every occupation? Yes  No Is the injured person partially disabled from occupation? Yes  No  If yes, please provide the percentage of disability \_\_\_\_\_

Prognosis of the ailment / injury \_\_\_\_\_

In Your opinion when will the injured person be able to resume duties? \_\_\_\_\_

I hereby to the best of my knowledge and belief, warrant the truth of the above details in every respect.

Place \_\_\_\_\_ Date \_\_\_\_\_ Reg.No. \_\_\_\_\_

Name, address and stamp of Medical Practitioner \_\_\_\_\_

Signature \_\_\_\_\_