

**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 insurance contract. 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 this 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. Use additional sheets, if required. We may call for additional document/information as relevant.

**A) Details of the Policy**

Policy Number (in full) \_\_\_\_\_  
 Certificate Number (for Group Policies) \_\_\_\_\_  
 Policy Commencement Date (DDMMYYYY) \_\_\_\_\_ Policy Expiry Date (DDMMYYYY) \_\_\_\_\_  
 Name of Policyholder \_\_\_\_\_  
 Claim Reference provided during intimation \_\_\_\_\_

**B) Details of the Insured Person**

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

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

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

**D) Details of the Claim**

Please tick the applicable benefit You want to claim for

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Medical Treatment        | <input type="checkbox"/> Dental Treatment       | <input type="checkbox"/> Medical Evacuation       | <input type="checkbox"/> Repatriation of Mortal Remains     |
| <input type="checkbox"/> Loss or Delay of Baggage | <input type="checkbox"/> Loss of Passport       | <input type="checkbox"/> Financial Emergency Cash | <input type="checkbox"/> Personal Accident & Common carrier |
| <input type="checkbox"/> Personal Liability       | <input type="checkbox"/> Hijack Daily Allowance | <input type="checkbox"/> Substitute Employee      | <input type="checkbox"/> Emergency Travel and Hotel         |
| <input type="checkbox"/> Trip Cancellation        | <input type="checkbox"/> Trip Delay             | <input type="checkbox"/> Trip Curtailment         | <input type="checkbox"/> Missed Connection                  |
| <input type="checkbox"/> Hospital Daily Allowance |   |   |   |

**E) Medical Treatment/Dental Treatment/Hospital Daily Allowance**

Please attach Doctor's reports, Original Admission/Discharge Card, Original Bills/Receipts/with Prescriptions and diagnostic/Investigative Reports, Copy of passport/visa with entry and exit stamp and copy of the ticket and boarding pass.

Name, Address and Contact Number of Treating Doctor/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) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If Accident, please provide details, i.e. how, when and where it took place.  
\_\_\_\_\_  
\_\_\_\_\_

Please enclose Police Report, if available.

Please provide the cost details for the Expenses (Bills, Invoices, Prescriptions etc) in Section M of this claim form and mention the currency.

Please tick  when You also claim for Hospital Daily Allowance.

#### **F) Medical Evacuation/Repatriation of Mortal Remains**

Please attach Doctor's reports, Original Admission/Discharge Card, Original Bills/Receipts/with Prescriptions and diagnostic/Investigative Reports, Copy of passport/visa with entry and exit stamp and copy of the ticket and boarding pass.

Name, Address and Contact Number of Treating Doctor/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 Death (DDMMYYYY) \_\_\_\_\_  
Cause of Death \_\_\_\_\_  
\_\_\_\_\_

Please attach the official Death Certificate and a Physician's statement for cause of death.

If Accident, please provide details, i.e. how, when and where it took place.  
\_\_\_\_\_  
\_\_\_\_\_

Please enclose Police Report, if available.

Please provide the cost details for the Expenses (Bills, Invoices, Prescriptions etc) in Section M of this claim form and mention the currency. Also, please provide, if applicable, name of the airline, burial details with bifurcation of incurred Expenses.

### G) 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 Airline Authorities/others about loss / delay of checked baggage, along with details of compensation received from Airlines/other authorities (if any), Property Irregularity Report (obtained from Airline), Copy of the passport/visa with entry and exit stamp, Adequate proof of ownership of items contained within checked-in-baggage valued in excess of the Indian rupee equivalent of US \$ 100 for loss of checked-in-baggage will need to be submitted.

Name of the Carrier \_\_\_\_\_

Flight 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 \_\_\_\_\_

Description of the items lost with regards to number, nature and cost of each item \_\_\_\_\_

\_\_\_\_\_

Description of items purchased with regards to number, nature and cost of each item \_\_\_\_\_

\_\_\_\_\_

Total Claim Amount \_\_\_\_\_

### H) Loss of Passport/Financial Emergency Cash

Please attach copy of new Passport, copy of previous Passport (if available), Original Bills/Invoices of expenses incurred for obtaining a new passport, copy of FIR/Police Report.

Date and time of Loss \_\_\_\_\_ Place of Loss \_\_\_\_\_

Description of the circumstances of Loss \_\_\_\_\_

\_\_\_\_\_

Application Document Fee \_\_\_\_\_

Incidental Cost \_\_\_\_\_

Amount of the fund lost \_\_\_\_\_

Total Claim Amount \_\_\_\_\_

### I) Personal Liability/Personal Accident and Common Carrier

Please attach Police Report, Post Mortem Report (in case of death), official Death Certificate (incase of death), Medical Report in the enclosed format, Certificate from Treating Doctor for Permanent Disability, Original photograph of the injured reflecting disablement, Judgment of the Court for Personal Liability.

Date and time of Accident \_\_\_\_\_

Place of Accident \_\_\_\_\_

Full description of the cause of accident \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Nature of Claim being made \_\_\_\_\_

\_\_\_\_\_

Court where the case is being pursued \_\_\_\_\_

\_\_\_\_\_

**J) Hijack Daily Allowance**

Please attach Police Report with details such as passport number and period of hijacking, copy of the Passport/visa with entry and exit stamp, newspaper reports/TV Clip or any other media coverage (if available).

Name of the Carrier \_\_\_\_\_  
Flight Number \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
Scheduled Departure Date and Time \_\_\_\_\_  
Scheduled Arrival Date and Time \_\_\_\_\_  
Date and Time of Hijack \_\_\_\_\_  
Actual Date and Time of return \_\_\_\_\_  
Description of the incident \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**K) Trip Delay/Trip Cancellation and Curtailment/Missed Connection**

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 Airline Authorities/others about delay/cancellation/curtailment, along with details of compensation received from Airlines/other authorities (if any), Original Admission/Discharge Card, Diagnostic /Investigative Reports of hospitalisation, official Death Certificate, copy of the Passport/visa with entry and exit stamp.

Name of the Carrier \_\_\_\_\_  
Flight Number \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
Scheduled Departure Date and Time \_\_\_\_\_  
Scheduled Arrival Date and Time \_\_\_\_\_  
Name of the Carrier \_\_\_\_\_  
Flight Number \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
Actual Departure Date and Time \_\_\_\_\_  
Actual Arrival Date and Time \_\_\_\_\_  
Description of incident \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please provide the cost details for the Expenses (Bills, Invoices, Prescriptions etc) in Section M) of this claim form and mention the currency.

**L) Substitute Employee/Emergency Travel and Hotel**

Please attach Doctor's Reports, Original Admission/Discharge Card, Diagnostic/Investigative reports, (copy of Passport/visa with entry and exit stamp and copy of the ticket and boarding pass for the Insured Person as well as Substitute employee), certificate from the employer establishing the official visit of both employees.

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

Please provide the cost details for the Expenses (Bills, Invoices etc) in Section M of this claim form and mention the currency.

**M) Details of Expenses**

No.	Expense Details	Issued by	Currency	Amount	Amount of received reimbursement	Remarks

**N) 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 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, 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 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.

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

Signature \_\_\_\_\_

**O) Medical Report (to be filled by Treating Doctor)**

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 Doctor \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_