Individual Personal Accident
Claim Form

ApolloMunich HEALTH INSURANCE
www.apollomunichinsurance.com

The issue of this form is not to be taken as an 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 evaluate your claim properly.

SECTION I: To be completed by the Policyholder / Insured Person or his representative

1. Details of the Policyholder

Policy no:

Name of policy holder:

2. Details of Insured Person / claimant (if the claimant is other than the Insured Person)
Have your registered communication address, mobile number or e-mail id been changed: yes/no

If yes, please provide latest modified details:

Name: (Mr./Ms./Mrs.)

First Name **Middle Name** **Last Name**

Address

Mobile No.: **Telephone No.:**

PAN No.: **Aadhaar no. :**

Occupation:

Note: Modified details would be endorsed to your policy

3. Policy holder bank details / Nominee bank details in case of death:

Please provide the following details of your bank account and attach a cancelled cheque / pass book copy pertaining to the same account.

Name as in Bank Account:

Bank Name:

Bank Branch:

Bank Account Number:

IFSC: **MICR No. :**

Note: It is agreed that the Policyholder/ Claimant will intimate in writing to Apollo Munich Health Insurance Co. Ltd. about any change in bank account details

4. Accident details:

Date of Injury/Death : D D M M Y Y Y Y **Time of Injury/Death:** A M P M

Place of Injury/Death :

Details/Narration of Injury/Death:

5. Whether the case is reported to Police: ☐ Yes ☐ No (If Yes, please complete the following)

If Yes, Name of Police Station:

Address of Police Station :

FIR No: **Date:** D D M M Y Y Y Y

6. Doctor consulted for the first time:

Name of the doctor:

Date of first consultation: D D M M Y Y Y Y

7. Has MLC being registered: ☐ Yes ☐ No (If Yes, please share below mentioned details)

MLC No. **Date:** D D M M Y Y Y Y

Place where registered:

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8. Were there admission in hospital ☐ Yes ☐ No (If Yes, please share below mentioned details)

Date of admission:	D D M M Y Y Y Y	**Date of discharge:**	A M P M
Time of admission:	D D M M Y Y Y Y	**Time of discharge:**	A M P M

9. Have you been referred subsequently to another doctor/hospital? ☐ Yes ☐ No (If Yes, please share below mentioned details)

Name of the doctor:

Name/Address of the hospital:

10. Declaration

I/We hereby warrant that: I have read and understood the policy terms, conditions and exclusions. The foregoing particulars are true and complete in all material respects. I/We also consent and authorize TPA/insurance company, to seek necessary medical information from hospital/medical practitioner who has attended on the person against whom this claim is made.

Date:_____ Place: _____

Signature of the Policyholder: _____ Signature of the Insured: _____

Signature of the Nominee: _____

(in case of death of policy holder)

11. For which benefits do you want to claim for? (Please tick (☐) the appropriate box)

Benefit	Amount	Benefit	Amount
☐ Accidental Death		☐ Accident Medical Expenses	
☐ Permanent Total Disablement		☐ Accident Hospitalization (In-patient)	
☐ Permanent Partial Disablement		☐ Broken Bones	
☐ Temporary Total Disablement		☐ Family Transportation	
☐ Transportation of Mortal Remains		☐ Purchase of Blood	
☐ Emergency Ambulance Charges		☐ Transportation of Imported Medicine	
☐ Education Fund		☐ Modification of Residence / Vehicle	
☐ Accident Hospital Cash		☐ Cost of Wheelchair/Crutches	
☐ Marriage Expenses for Children		☐ Widowhood Cover	
☐ Cremation ceremony		☐ Coma	
☐ Accident Hospitalization (Outpatient)		☐ Others	
☐ Carrier		**Total Claimed Amount**	

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Please attach the following documents (please tick (✓) the appropriate box)

List - I (Accidental Death/Carrier – in case of Accidental Death)
- ☐ Copy of FIR (First Information Report) /Spot Panchnama / Inquest Panchnama
- ☐ Death Certificate
- ☐ Original death summary
- ☐ Post Mortem Report
- ☐ Original legal heir certificate (in case nomination has not been filed by deceased)

List - III (Transportation of Mortal Remains)
- ☐ All Documents of List – I (accidental death)
- ☐ Original Bills and payment receipt of transportation

List - IV (Emergency Ambulance Charges)
- ☐ All documents of List – I (accidental death) or List – II (PTD/PPD/TTD)
- ☐ Original Bills and payment receipt
- ☐ Treating Doctor's consultation indicating Emergency care

List - II (Permanent Total Disablement/Carrier-in case of Permanent Total Disablement/Permanent Partial Disablement/Temporary Total Disablement)
- ☐ Copy of FIR (First Information Report)
- ☐ Original treating doctor certificate describing disablement (If claiming for PTD/PPD)
- ☐ Original Discharge summary from the hospital (If admitted in hospital)
- ☐ Original photograph of the injured reflecting disablement (If claiming for PTD/PPD)
- ☐ Prescription and consultation papers
- ☐ Leave certificate from the employer (If Employed)
- ☐ Disability Certificate issued by Civil Surgeon or equivalent as authorized by State Government (If claiming for PTD/PPD)
- ☐ Medical reports, case histories, investigation reports, treatment papers, all x-ray films as applicable.
- ☐ Copy of MLC (Medico legal certificate)
- ☐ Last filled ITR – income tax return (If businessman/businesswoman)
- ☐ Last 3 months salary slip (If employed)

List – V (Accident Medical Expenses / Hospitalization –Inpatient/ Outpatient)
- ☐ Original Discharge summary from the hospital (If claiming for in-patient)
- ☐ Medical Bills with Prescription
- ☐ Medical reports, case histories, investigation reports, treatment papers, all x-ray films as applicable.
- ☐ First Consultation and subsequent prescription
- ☐ Copy of MLC (Medico legal certificate)
- ☐ Copy of FIR (First Information Report)

List - VI (Broken Bones)
- ☐ Same as the documents of List - II (PTD/PPD/TTD)
- ☐ X-ray reports and films reflecting the fracture/s

List - VII (Family Transportation)
- ☐ All documents of List – I (accidental death) or List – II (PTD/PPD/TTD)
- ☐ Original Bills and payment receipt
- ☐ Proof of the immediate family member such as Ration Card List

List - VIII (Transportation of Imported Medicine)
- ☐ All documents of List – I (accidental death) or List – II (PTD/PPD/TTD)
- ☐ Treating doctor certificate mentioning the indication
- ☐ Bill of Loading of medicine
- ☐ Original Medicine bill and payment receipt
- ☐ Reason for Import

List - IX (Purchase of Blood)
- ☐ All documents of List – I (accidental death) or List – II (PTD/PPD/TTD)
- ☐ Original Bills and payment receipt of blood purchase
- ☐ Treating doctor certificate mentioning the indication

List - X (Education Fund)
- ☐ All documents of List – I (accidental death) or List – II (PTD/PPD/TTD)
- ☐ Study Certificate from the school of the dependent child mentioning the parent's name

List - XI (Modification of Residence/ Vehicle)
- ☐ All documents of List – I (accidental death) or List – II (PTD/PPD/TTD)
- ☐ Original Bills and payment receipt

☐ **List – XII (Widowhood Cover)**
- ☐ All documents of List – I (accidental death)
- ☐ Marriage certificate

List - XIII (Marriage expenses for children)
- ☐ All documents of List – I (accidental death) or List – II (PTD/PPD/TTD)
- ☐ Proof of unmarried dependent children (affidavit and age proof)
- ☐ Proof of marraige

List - XIV (Cost of Wheel chair/Crutches)
- ☐ All documents of List – II (PTD/PPD/TTD)
- ☐ Original bills and payment receipt
- ☐ Prescription of doctor mentioning the indication

List - XV (Coma)
- ☐ All documents of List – II (PTD/PPD/TTD)
- ☐ Original bills and payment receipt

List - XVI (Cremation Ceremony)
- ☐ All documents of List – I (accidental death)
- ☐ Original bills and payment receipt

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SECTION III: To be completed by the Doctor who originally treated the injuries

1) Name of the Injured Person: _____

2) Gender: ☐ Male / ☐ Female

3) Date of Birth (DD/MM/YYYY) and age: _____

4) Has the patient sustained a similar injury previously or aggravated a pre-existing condition? ☐ Yes ☐ No

5) Describe nature and cause of injury: _____

_____

6) Date you first examined the patient for this injury (DD/MM/YYYY): _____

7) According to you, how long should the injured person be confined to bed/house as the direct and sole consequence of the injury sustained?

From (DD/MM/YYYY) : _____ To (DD/MM/YYYY) : _____

a) During this period will the injured person be able to attend to his/her normal duties? ☐ Yes ☐ No

b) If Yes, from what date (DD/MM/YYYY) : _____

c) If No, please state probable date of his/her being able to attend to his/her normal duties (DD/MM/YYYY): _____

8) Was he/she under the influence of intoxicants or drugs at the time of accident? _____

I have personally examined the above named Insured Person. I certify that the above statements are correct and that the Insured Person is necessarily disabled by the Accident.

Name of the Doctor: _____ Contact no.: _____

E-mail: _____

Address: _____

Date: _____ Place: _____

Signature of the Doctor:

Stamp:

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CUSTOMER IDENTIFICATION PROCEDURE (AS PER KYC NORMS OF IRDA)

Please submit clear and legible copy of one document (valid and effective as on date of claim submission) each from Part A and Part B and your recent passport size photograph (not more than 6 months old) incase claim amount exceeds INR 100,000.

Photograph

Part A **Proof of legal name and any other names used**	i. Pan Card ii. If Pan Card is not available please submit any of the documents mentioned below stating reason for not having Pan Card. a) Passport b) Voter's Identity Card c) Driving License d) Personal Identification and Certification of the employees for your identity. e) Letter issued by Unique identification Authority of India containing details of name address and Aadhar Number f) Job Card issued by NREGA duly signed by an officer of the State Government
Part B **Proof of Residence**	i. Electricity Bill not older than 6 months from the date of claim submission ii. Telephone Bill pertaining to any kind of telephone connection like mobile, landline, wireless etc. Provided it is not older than 6 months from the date of claim submission iii. Ration Card iv. Valid lease agreement along with rent receipts which is not more than 3 months old as a residence proof v. Saving Bank Passbook with details of permanent/ present residence address (updated upto 1 month prior to claim submission document) vi. Statement of saving bank account with details of present/ present address (updated upto 1 month prior to claim submission document)

hereby declare that I have submitted above mentioned documents and recent photograph (not more than 6 months old) for the purpose of claim and the said documents are valid and effective.

Date : _____

Signature of Policyholder : _____

Apollo Munich Health Insurance Co. Ltd. • 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog Vihar, Phase-III, Gurgaon-122016, Haryana • Corp. Off. 1st Floor, SCF-19, Sector-14, Gurgaon-122001, Haryana • Reg. Off. Apollo Hospitals Complex, 8-2-293/82/J III/DH/900 Jubilee Hills, Hyderabad-500033, Telangana • Insurance is the subject matter of solicitation • For more details on risk factors, terms and conditions, please read sales brochure carefully before concluding a sale • IRDAI Registration Number - 131 • CIN: U66030TG2006PLC051760