Easy Health
Claim Form

ApolloMunich HEALTH INSURANCE

10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

PART A

TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability

1. Policy No. : ______ 2. Sl. No/ Certificate No. : ______ 3. Company/ TPA ID No : ______
4. Name & Address of the Policyholder : ______
5. Details of the Insured Person Hospitalised :
   - a) Name : ______
   - b) Relationship : ______ c) Date of Birth : ______ d) Age/Years : ______
   - e) Address : ______
   - f) Gender: Male ☐ / Female ☐ g) Occupation : ______
   - h) Telephone No : ______ i) Mobile No : ______
   - j) E-mail ID, if any : ______
6. Hospitallisation due to Illness ☐/ Injury ☐/ Maternity ☐ : Details : ______
   - a) Date of Injury sustained/ Disease first detected / LMP : ______
   - b) If injury, how it occurred : ______
   - c) If injury, whether Medico legal : Yes ☐ / No ☐ d) If MLC, whether reported to police? Yes ☐ / No ☐
   - e) System of medicine : Allopathic ☐ / Other systems of medicine ☐
7. Insurance History :
   - a) Date of commencement of first Insurance for the person (without break) : ______
   - b) Are you presently covered with any other Mediclaim / Health Insurance? : Yes ☐ / No ☐
   - c) If Yes, give details - Company / Policy Number / Sum Insured (copies of policies to be attached) : ______
8. Name of the Hospital where admitted : ______
9. Room Category occupied : Day care ☐ / Single occupancy ☐ / Twin sharing ☐ / 3 or more ☐
10. Past Hospitalisation History :
    - a) Have you been hospitalised in the last 4 years? : Yes ☐ / No ☐
    - b) If Yes, Diagnosis : ______
    - c) Month and Year : ______
11. Is claim is for Domiciliary Hospitalisation? : Yes ☐ / No ☐ (If Yes, provide details in annexure)
12. Policyholder's Bank Account particulars :

    Payable details: Cheque ☐ / DD ☐ / NEFT * ☐ Payable to : ______

    Bank Name : ______ Bank Branch : ______

    Bank Account Number : ______ IFSC Code : ______

    MICR No. : ______ Policyholder's PAN : ______

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

    *Please attach a cancelled cheque pertaining to the same account.
13. Details of the treatment expenses claimed :
    - a) Pre-hospitalisation Expenses : Rs. ______ b) Hospitalisation Expenses : Rs. ______
    - c) Post-hospitalisation Expenses : Rs. ______ d) Health check-up Cost : Rs. ______
    - e) Ambulance Charges : Rs. ______ f) Others (code) : Rs. ______

13A. Details of Lumpsum / cash benefit claimed :
   - a) Hospital Daily Cash : Rs. ______ b) Surgical Cash : Rs. ______
   - c) Critical Illness Benefit : ______ d) Convalescence : ______
   - e) Pre / Post hospitalisation lumpsum benefit : ______
   - f) Others : ______

14. Details of bills enclosed :

Sl. No.	Bill No.	Date	Issued by	Towards	Amount

(If there is insufficient space to provide additional relevant information, whether as requested or otherwise, please attach extra sheet duly signed.)

15. For details of Claim Documents to be submitted, please refer CHECK LIST.

Date : ______ Signature of the Policyholder / Claimant : ______