Broad Guidelines for Claim Process

1. Please ensure Claim form is completely filled, signed and **submitted in original.**
2. Please provide at least **two contactable mobile numbers and e-mail id** for further communication related to your claim.
3. Indicative list of claim documents has been provided in the Claim Form under Section E. **Please ensure all the documents are submitted in original for smooth processing of claim.**
4. **Claim processing will be delayed in absence of original documents.**
5. **Claim payments are made only through Online Bank Transfers.** Please submit the Bank Account details along with a cancelled cheque. The bank accounts details need to be mentioned in Section G of the Claim Form.

In addition to above, if the claim amount is more than Rs 1 Lakh then following additional documents are required:

6. KYC Documents (If Applicable)

Claim documents needs to be send on below address: -
Care Health Insurance-Claims Department
Vipul Tech Square, Tower C, 3rd Floor, Golf Course Road,
Sector-43, Gurugram-122009 (Haryana)

Now, track your claim status with ease
ONLINE : Please visit below link and enter your Client ID and Policy Number
www.careinsurance.com/claim_search.php **Center/Claim Search/Enter Client ID and Policy No.**

SMS : Simply SMS your claim reference number in the message format CLAIM <space> CLAIM NUMBER to 77158-77158
Example: To check claim status of claim reference number 11223344, simply SMS CLAIM 11223344 to 77158-77158

Brief description of the key documents required along with the claim form

1. Indoor Case Papers - This document is prepared by hospital on daily basis which maintains daily doctor notes, nursing notes, patient progress details and having patient condition summary from the date of admission till discharge.
2. Hospital Discharge Summary - Summary of hospitalization period including - Admission date, discharge date, diagnosis, line of treatment given to patient during hospitalization and further advice on discharge.
3. Payment Receipts - Receipts of payment done to hospital authorities towards all bills, investigation reports or any other procedure done.
4. Consultation Papers - Written prescription of the Medical Practitioner with whom patient has consulted.
5. **NEFT (Net Electronic Fund Transfer) – We require original cancelled cheque of the policyholder and relevant details to be mandatorily filled under Sector-G of claim form.**

Terms and Conditions for Payments through RTGS/NEFT

1. The details provided by the policyholder in the mandate form shall be considered as final and Care Health Insurance Limited shall not be responsible for cross verifying of any of the details provided therein.
2. The policy holder agrees that transaction through RTGS/NEFT facility may attract inward RTGS/NEFT charges, which if levied by the policyholder's bank shall be borne by the policy holder only.
3. Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company.
4. I/We further undertake to refund any excess amount whether demanded by Care Health Insurance Limited or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from Care Health Insurance Limited of such excess credit or such information of excess credit coming to the knowledge of the policy holder through any other source.
5. The policyholder agrees that under RTGS/NEFT facility, there may be risk of non-payment in the policyholder accounts number on the day of the credit of payments due to change in the applicable regulations pertaining to RTGS/NEFT facility or due to any other reasons without any fault/inaction/failure on part of Care Health Insurance Limited or any factor beyond the control of Care Health Insurance Limited.

Care Health Insurance Limited
Registered Office: 5th Floor, 19 Chawla House,Nehru Place,New Delhi-110019 Correspondence Office: Vipul Tech Square, Tower C, 3rd Floor, Golf Course Road, Sector-43, Gurugram-122009 (Haryana) Website: www.careinsurance.com CIN: U66000DL2007PLC161503 UIN: CHITIOA24133V012324 IRDAI Registration No. - 148

care HEALTH INSURANCE

Claim Form - 'Explore Advantage'

1) Please give the required information correctly and completely to enable us to process your claims promptly.
2) Use additional sheets, if required.
3) We may call for additional documents/ information as relevant.
4) The claim form should be supported by all the documents as specified in the Policy.
5) The issue of this form shall not to be taken or deemed to be taken as an admission of liability by the Company.

(To be filled in block letters)

Claim Intimation No._____

Section A - Details Of Primary Insured Person

a) Add-on Policy No.:

b) SL No./Certificate No.: c) Company/TPA ID No.:

d) Base Policy No :

e) Name :
(Surname) (First Name) (Middle Name)

f) Address :

City :

State : Pin Code :

Mobile : E-mail :

Section B - Details Of Insured Person / Claimant

a) Name :

b) Gender : M F c) Age : / (YY/MM) d) Date of Birth : / /

e) Relationship with Primary Insured : Self Spouse Child Father Mother

Other (Please Specify) _____

f) Occupation : Service Self Employed Homemaker Retired Student Others (Please Specify) _____

g) Address :

(if different from above)

City :

State : Pin Code :

Landline : - Mobile :

E-mail :

Section C - Details Of Claim

S. No.	Add-on Name	Yes / No
Base Benefit 1	Emergency Hotel Accommodation	
Base Benefit 2	Staff Replacement	
Base Benefit 3	Sports Cover	
	i. Sports Equipment hire ii. Rented sports equipment damage or loss iii. Sports Activity Coverage	
Base Benefit 4	Loan Protector	
Base Benefit 5	Airfare Allowance	
Base Benefit 6	Self-Driven Rental Car Excess	

Base Benefit 7	Alternate Transport Expenses	
Base Benefit 8	Extended Pet Stay	
Base Benefit 9	Event Cancellation	
Base Benefit 10	Enhanced Trip Cancellation & Interruption	
Base Benefit 11	Burglary (Home Contents)	

1) Additional Details for Emergency Hotel Accommodation

(I) Cause of the Illness / Injury :_____

(ii) Was the Illness/incident caused/ aggravated due to a pre-existing condition? ☐ Yes ☐ No

Please give details:_____

(iii) Nature of treatment :_____

(iv) Treating Doctor's opinion on how many more days the patient will need to be hospitalized: ☐☐☐

(v) Treating Doctor's opinion on need for an attendant:_____

(vi) Name of the Attendant : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(vii) Insured Person relationship with Attendant: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(viii) Details of Journey from : ☐☐☐☐☐☐☐☐☐☐ To : ☐☐☐☐☐☐☐☐☐☐ ,Total No. of Days ☐☐☐

(ix) Scheduled Return Date of Insured Person: ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

(x) Actual Return Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

(xi) Total Accommodation Expenses : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Documents to be submitted in support of the Claim:

- A certification from the Medical Practitioner recommending the presence in the form of special assistance to be rendered by an additional member during the entire period of Hospitalization. The certificate shall also specify the minimum period in which person is admitted in the hospital.
- Discharge summary of the Hospital furnishing details including the date of admission and date of discharge.
- Copy of the tickets booked for the travel of Immediate Family Member, which should be after the date of certificate issued by the Medical Practitioner.
- Copy of passport of Immediate Family Member with entry and exit stamp of immigration which should be after the date of certificate issued by Medical Practitioner.
- Bills and payment receipts for accommodation bookings

2) Staff Replacement

(I) Cause of the Illness / Injury :_____

(ii) Was the Illness/incident caused/ aggravated due to a pre-existing condition? ☐ Yes ☐ No

Please give details:_____

(iii) Nature of treatment:_____

(iv) Treating Doctor's opinion on how many days Insured Person will be unable to carry out his/her occupational duties: ☐☐☐

(v) Name of the substitute person (Employee) : _____

(vi) Substitute person employee ID no. / proof:_____

(vii) Any other dDetails of substitute person:_____

(viii) Occupation Details : _____

(ix) Total Expenses : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Documents to be submitted in support of the Claim:

- A certification from the Medical Practitioner specifying the minimum period of Hospitalization.
- Discharge summary furnishing details including the date of admission and date of discharge.
- Copy of the tickets booked for the travel of Employee (substitute of Insured Person), which should be after the date of certificate issued by the Medical Practitioner and pre-booked return ticket before the start of the journey.
- Copy of passport of the Employee (substitute of Insured Person) with entry and exit stamp.

3) Sports Cover

I. Sports Equipment Hire

(I) Type of Loss : _____

(ii) Date of Loss : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

(iii) Place of Loss : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(iv) Whether reported to the police? ☐ Yes ☐ No

(v) Details of Loss :_____

_____

- Details of sports equipment taken on rent:_____

- Date and Place of Renting sports equipment:_____

- Total Expenses : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Documents to be submitted in support of the Claim:

- FIR copy of the lost item/(s).
- Original bill or bill copy (if original bill not available) for sports equipment or proof of purchase of the lost item/(s).
- Rent Receipt or bill of rented sports equipment or proof of rental purchase.
- Passport copy with entry and exit stamp.
- Written statement from Insured Person narrating the incident of loss i.e. type of loss, causes, circumstances and the place.
- Communication from the common carrier/airlines confirming baggage containing the sports equipment is lost (in case sports equipment is lost by Common Carrier)

II. Rented Sports Equipment Damage or Loss

(I) Type of Loss : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(ii) Date of Loss : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

(iii) Place of Loss : ☐☐ ☐☐

(iv) Whether reported to the police? ☐ Yes ☐ No

(v) Details of rented equipment damage or loss :_____

_____

(vi) Penalty/ fine charged by the sports equipment owner:_____

Documents to be submitted in support of the Claim:

- FIR copy of the lost/damaged item/(s).
- Rent Receipt or bill copy (if original bill not available)for sports rented equipment or proof of purchase of the lost item/(s).
- Passport copy with entry and exit stamp.
- Written statement from Insured Person narrating the incident of loss / Damage i.e. type of loss/ damage, causes, circumstances and the place.
- Proof that equipment was not damaged before Insured Person took the possession of the same.

III. Sports Activity Coverage

(I) Cause of the Illness / Injury :_____

(ii) Was the Illness/incident caused/ aggravated due to a pre-existing condition? ☐ Yes ☐ No

(iii) Please give details:_____

(iv) Nature of treatment :_____

(v) Whether treating Doctor has given written advise to NOT take part in the sports activities? ☐ Yes ☐ No

Note - In case of loss due to trip interruption: fill the details in "Trip Interruption" section.

S.No.	Expense Details	Amount
	Total :	

Documents to be submitted in support of the Claim:

- Medical Certificate and / or discharge summary from the Medical Practitioner attending the patient.
- Invoices and receipts of sports activities for which Insured Person has paid.
- Any other document as applicable and required under Benefit "Trip Interruption" under Base Policy or Benefit 10 under this Add-on Policy.

4) Loan Protector

(I) Details of incident:_____

(ii) Date and Place of accident: _____

(iii) Date of first treatment & nature of treatment:_____

(iv) Please describe in detail the nature of the Insured Person's injuries:_____

_____

(v) Date and Place of Death:_____

(vi) Provide name, address & telephone number of Hospital/ Clinic:_____

_____

(vii) Name of Attending Physician:_____

(viii) Loan Account No:_____

(ix) Loan Type: _____

(x) Any other details of Loan:_____

Documents to be submitted in support of the Claim:

- Medical reports giving the details of the Accident, nature of the Injury and the details of treatment provided.
- Death certificate
- Postmortem report
- Police report
- Documentary proof of outstanding loan against Insured Person on the date of death by Financial Institution / Bank.
- Any other document as specified by local authority.

5) Airfare Allowance

(I) Cause of the Illness / Injury : _____

(ii) Name & No. of original scheduled Common Carrier: _____

(iii) Original Schedule return date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Time : ☐☐ : ☐☐ (HH:MM)

(iv) Name & No. of actual Common Carrier :_____

(v) Actual revised return date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Time : ☐☐ : ☐☐ (HH:MM)

(vi) Additional expenses incurred due to difference in airfare: _____

Documents to be submitted in support of the Claim:

- Details and status of original booking and new bookings for travel with tickets, invoices.
- Discharge summary furnishing details including the date of admission and date of discharge.
- Passport copy with entry and exit stamps.
- Proof of refund (if any) is provided by Airlines.

6) Self-Driven Rental Car Excess

(I) Date & Place of Renting Self-Driven Rental Car:_____

(ii) Details of Self-Driven Rental Car : _____

(iii) Date & Time of incident: ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Time : ☐☐ : ☐☐ (HH:MM)

(iv) Details of incident: _____

_____

(v) Place of Loss/ Accident: _____

(vi) Loss Amount: ☐☐☐☐☐☐☐☐

(vii) Total Insurance excess / deductible amount: ☐☐☐☐☐☐☐☐

Documents to be submitted in support of the Claim:

- Copy of car rental agreement.
- A police report/ FIR confirming the incident.
- Copy of valid International driving license.
- Proof that car was not damaged before Insured Person took the possession of the same.

7) Alternate Transport Expenses

(i) Description of Incident : _____

(ii) Reason for cancellation/ delay/shortening/ divert of scheduled transport arrangement :_____

_____

(iii) Details of event or prepaid travel/tour arrangements: _____

(iv) Name of the Common Carrier:

(v) Common Carrier No.:

(vi) Scheduled Arrival Date: / / (DD/MM/YYYY) Time : : (HH:MM)

(vii) Scheduled Departure Date: / / (DD/MM/YYYY) Time : : (HH:MM)

(viii) Common Carrier route: From: To:

(ix) Details of alternate transport taken:

(x) Name of the Common Carrier:

(xi) Common Carrier No. :

(xii) Actual Arrival Date : / / (DD/MM/YYYY) Time : : (HH:MM)

(xiii) Actual Departure Date : / / (DD/MM/YYYY) Time : : (HH:MM)

(xiv) Common Carrier route: From: To:

(xv) Details of alternate booking expenses:

Alternate Booking Reference No.	Expense Details	Booking Amount	Refund Amount	Expenses incurred (in ₹)

(xvi) Total Expenses :

Documents to be submitted in support of the Claim:

- Details and status of original booking and new alternate transport bookings for travel with tickets, invoices.
- Confirmation in writing from the Common Carrier certifying the delay/ cancellation/ diversion/ shortening of trip & actual date and time of arrival.
- Passport copy with entry and exit Stamp.
- Proof of refund (if any) is provided by Airlines.

8) Extended Pet Stay

(I) Details of Pet: _____

(ii) Reason for delayed return to India :_____

(iii) Description of Incident : _____

_____

(iv) Scheduled Arrival Date : / / (DD/MM/YYYY) (v) Time : : (HH:MM

(vi) Actual Arrival Date : / / (DD/MM/YYYY) (vii) Time : : (HH:MM

(viii) Date and Time when pet transferred to Pet House :

(ix) Date and Time when pet custody taken back from Pet House :

Documents to be submitted in support of the Claim:

- Receipts for fees paid to Pet house.
- Letter from the airlines stating reason and duration of delay.
- Passport copy with entry and exit Stamps.
- Medical records in case of Insured Person's or travelling companion's Hospitalization.
- Copy of pet license from local authority.

9) Event Cancellation

(I) Details of Event : _____

(ii) Reason of cancellation_____

(iii) Details of Expenses

Details	Ticket Cost	Refund Amount	Expenses incurred (in ₹)

(iv) Total Expenses : | | | | | | | | | | |

Documents to be submitted in support of the Claim:

- Tickets and invoices of special event booked.
- Written confirmation / documentary proof with reason from the organizers or promoters that the event is cancelled / curtailed.

10) Enhanced Trip Cancellation & Interruption

Name of Common Carrier:_____

Scheduled departure: Date: | | / | | / | | | | | (DD/MM/YYYY) Time : | | : | | (HH:MM)

Scheduled arrival: Date: | | / | | / | | | | | (DD/MM/YYYY) Time : | | : | | (HH:MM)

Common Carrier route: From: _____ To: _____

Name of Common Carrier :_____

Actual departure: Date: | | / | | / | | | | | (DD/MM/YYYY) Time : | | : | | (HH:MM)

Actual arrival: Date: | | / | | / | | | | | (DD/MM/YYYY) Time : | | : | | (HH:MM)

Common Carrier route: From: _____ To: _____

Description of incident: _____

Total expenses _____

Note - Documents to be submitted in support of the Claim shall be same as stated under "Trip Cancellation" & "Trip Interruption" of Base Policy.

11) Burglary (Home Contents)

Date and time of loss: | | / | | / | | | | | (DD/MM/YYYY) Time : | | : | | (HH:MM)

Police complaint lodged: | | Yes | | No

Date and time of Police complaint, if lodged: _____

Is the Insured Person the sole owner of:

a) The property lost or damaged | | Yes | | No

b) The Premises | | Yes | | No

Give brief details of loss occurred with list of article stolen / damaged:

Documents to be submitted in support of the Claim:

a) Purchase Invoice detailing the date of purchase, value on the date of purchase etc. for the lost or damaged item.

b) Written complaint with the police listing out the items with values that were lost, damaged or destroyed.

c) Details of damaged or stolen item such as quantity, age, description, actual cash value and amount of loss claimed for in respect of each item, along with all documentation in support.

d) Any other document as required by the Company to assess the Claim.

Section D : Details Of Primary Insured Person's Bank Account

a) PAN :

b) Account Number :

c) Bank Name and Branch :

d) Cheque/DD Payable details :

e) IFSC Code :

Section E : declaration By The Insured Person

a. I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize assistant service provider / insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

b. I hereby authorize the Company or its Assistance Service Provider to conduct Autopsy / Post Mortem for the Insured Person, wherever required.

c. I hereby authorize the physician or hospital or police authorities or governmental agency or any other institute to provide to Care Health Insurance Limited, or its offices or legal advisers or any investigative agency or their representative acting on its behalf, information regarding the deceased's state of health, employment, finances or insurance, advice, treatment provided to the deceased or any information that may be required concerning the health of the deceased including information relating to mental illness, use of drugs, use of alcohol. A copy of this authorization shall be considered as effective and valid as the original.

d. The details of all persons having an interest in the property in respect of which the claim is being made are provided as per the proposal form or by way of an endorsement in the policy. Furthermore, save and except as provided or disclosed in this claim form, no claim made hereunder (or the same/ similar claim) has been made or lodged with any other insurance company.

e. If I/ We have given/ made any false or fraudulent statement/ information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I/ We shall not be entitled to all/any rights to recover thereunder in respect of any or all claims, past, present or future.

f. The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information and documents in respect of the claim.

g. I do hereby authorize International Subrogation Management (ISM) to inquire and obtain any information regarding my accident. Further, Care Health Insurance Limited is hereby authorized to release any and all information, including copies of pertinent documents, which ISM may deem necessary in order to satisfy their inquiry, If during the investigation, ISM has identified a potential recovery source, allowing to recover paid benefits, ISM is authorized to release any all records they deem necessary in order to pursue the recovery.

h. The company can, while assessing the claim, call for the additional documents which the Company deems fit for assessment of the claim.

Date: / / (DD/MM/YYYY)

Place:_____

Signature of the Insured Person: _____