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.

Claim Form - 'explorē protect plus'

Claim Form

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.

Section A - Details of The Policy

Add-on Policy Number	
Insured Name	
Certificate of Insurance Number	
Base Policy Number	

Section B - Details of Insured Person / Claimant

Name							
Address							
City		State		Country		Pin code	
Contact Number							
E-mail							

Section C - Details of Claim

If a claim is made for any of the following Benefits kindly tick the appropriate Benefit and fill in the corresponding below details:-

Refund of Visa Fee ☐

Date of Application: ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)
Visa rejection Date: ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)
Reason of Visa rejection _____
Visa Application/documentation fees _____
Claim Amount _____

Trip Cancellation & Interruption ☐

Name of Common Carrier: _____
Scheduled departure: Date ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Time (HHMM) ☐☐☐☐
Scheduled arrival: Date ☐☐ / ☐☐ / ☐☐☐☐ (DDMMYYYY) Time (HHMM) ☐☐☐☐
Common Carrier route: From: _____ To: _____
Name of Common Carrier : _____
Actual departure: Date ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Time (HHMM) ☐☐☐☐
Actual arrival: Date ☐☐ / ☐☐ / ☐☐☐☐ (DDMMYYYY) Time (HHMM) ☐☐☐☐

Common Carrier route: From: _____ To: _____

Description of incident: _____
Total expenses _____

Loss of Checked-in Baggage ☐

Name of Common Carrier _____

Date and time of departure: ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Time (HHMM): ☐☐☐☐

Date and time of arrival : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Time (HHMM): ☐☐☐☐

Port of disembarkation: _____

Property irregularity report by carrier attached ☐ Yes ☐ No

Claim lodged on carrier ☐ Yes ☐ No

Police report lodged ☐ Yes ☐ No

Serial No.	Description of Items Lost	Amount(Rs)

Burglary (Home Contents) ☐

Date and time of loss: ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Time (HHMM): ☐☐☐☐

Police complaint lodged : Yes ☐ No ☐

Date and time of Police complaint, if lodged: : _____

Is the insured 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

Section D- Declaration

I/We hereby agree, affirm and declare that:

a. The information/statements given/ stated by me/us in this claim form are true, correct and complete.

b. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.

c. 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 there under in respect of any or all claims, past, present or future. The receipt of this claim form/other supporting/related documents does not constitute or deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further information and documents in respect of the claim.

d. 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.

e. I do hereby authorize Subrogation Agency to inquire and obtain any information regarding my accident. Further, the Company is hereby authorized to release any and all information, including copies of pertinent documents, which Subrogation Agency may deem necessary in order to satisfy their inquiry, If during the investigation, Subrogation Agency has identified a potential recovery source, allowing the Plan Participant's employer to recover paid benefits, Subrogation Agency is authorized to release any all records they deem necessary in order to pursue the recovery

Place: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date: ☐☐ ☐☐ ☐☐☐☐ Signature of the Claimant

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: CHITGOA23168V012223 IRDAI Registration No. - 148