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: IRDA/NL-HLT/RHI/P-P/V.I/255/13-14 IRDAI Registration No. - 148

care HEALTH INSURANCE

Claim Form - 'Group Secure'

To be filled by the Insured. Please fill in CAPITAL only.

Claim No.: _____

Policy Details

Policy No. :

Date of Inception : / / (DD/MM/YYYY)

Group/Company Name :

Details of the Insured Person in respect of whom claim is made

Name of Insured Member :

Name of the Insured :

Date of Birth of Insured : / / (DD/MM/YYYY)

Relationship with the Insured Member :

Gender of Insured : M F

Address :

City :

State : Pin Code :

Landline : - Mobile :

E-mail :

Primary Insured's Bank Details

Bank :

Account Number :

Branch :

PAN :

Cheque/DD No. :

IFSC/Swift Code :

Details of Hospital/Nursing Home in which treatment was taken

Name of the Hospital :

Address :

City :

State : Pin Code :

Landline : -

E-mail :

Registration No. and Rubber Stamp of the Hospital :

Date of Admission : / / (DD/MM/YYYY) Time of Admission : : (HH:MM)

Date of Discharge : / / (DD/MM/YYYY) Time of Discharge : : (HH:MM)

Details of Attending Medical Practitioner/Doctor/Treating Physician or Surgeon

Name of the Treating Doctor :

Qualification :

Registration No. :

Address :

City :

State : Pin Code :

Landline : - Mobile :

E-mail :

Claim Details

Date of Accident : / / (DD/MM/YYYY)

Time of Accident : : (HH:MM)

Place of Accident :

What were you doing at the time of Injury? _____

Name of Witness :

Address :

City :

State : Pin Code :

Landline : - Mobile :

E-mail :

Brief explanation by the witness (if any) : _____

If more than one witness, please provide additional details on a separate sheet.

Whether FIR Filed? Yes No If Yes, FIR No. : _____

Date of Admission : / / (DD/MM/YYYY) Date of Discharge : / /

Nature of Claim : Non-Fatal Injury Fatal Injury

Non-Fatal Injury

Nature of Injury :

Nature of Disablement :

Extent of Disablement : _____

(Percentage of disability as assessed by the attending doctor)

Period of Temporary Total Disablement : (No. of Days)

Total Period of Confinement : From / / (DD/MM/YYYY) To / /

(From date of accident till recovery)

Fatal Injury

Cause of Death as per attending doctor :

Post mortem - 1) Date : / / (DD/MM/YYYY)

2) Hospital :

Are the injuries referred to the sole and direct cause of your being rendered completely disabled from attending to your usual business or occupation?

☐ Yes ☐ No

If Yes, I was totally disabled : From ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) To ☐☐ / ☐☐ / ☐☐☐☐

Have you, since the accident been able to attend to your business or occupation in Part only? ☐ Yes ☐ No

If Yes, I was partially disabled : From ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) To ☐☐ / ☐☐ / ☐☐☐☐

What hours and duties are you working? ☐☐☐ Days ☐☐☐☐ Hours

During the 24 hours before the injury, did you drink any alcohol or take any drugs? ☐ Yes ☐ No

State types & quantities

Are you at present totally disabled? ☐ Yes ☐ No

If Yes, when do you consider you will be able to attend to

(I) Some of your Business or Occupation : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

(II) The whole of your Business or Occupation : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Is this injury or condition a resultant of your work environment? ☐ Yes ☐ No

If yes, how exactly did it occur? ______________________________

____

Have you ever had this or a similar condition in the past? ☐ Yes ☐ No

Date(s) : ______________________________

Treatment received : ______________________________

____

Name of treating Doctors/Specialists : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

What other significant medical or surgical treatment have you received in the past 5 years? ______________________________

____

Date(s) : ______________________________

Nature of the condition(s) treated : ______________________________

Name of treating Doctors/Specialists : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Are you affected by any other long term or chronic disability? ☐ Yes ☐ No

Provide details : ______________________________

Please provide detail of your regular Practitioner :

Name : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Address : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Contact No. : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Amount of claim (Please mention & include under what head claims are lodged viz. Medical expenses, funeral expenses, Children educational grant etc. & attach separate sheet if the space is insufficient)

S No.	Details	Bill No.	Date	Amount (₹)
1			(DD/MM/YYYY)	
2				
3				
4				
5				
6				
			Total	

Details of Other Policy

Do you have accident insurance policy with any other insurance company? If yes, please provide the following details :

Name of the Insurance Company	Policy Number	From	To	Sum Insured (₹)

Please attach additional sheet to specify any other documents appended, if required, as per the policy details

S No.	Type of Document	Tick
1	Duly filled and signed claim form	
2	Hospital Payment Receipt	
3	Pharmacy Bills	
4	Investigation Reports/Reports Name	
5	Discharge Summary	
6	Operation theater notes	
7	Hospital Main Bill	
8	Copy of First Information Report (FIR)	
9	Hospital Breakup Bill	

S No.	Type of Document	Tick
10	Copy of the medico-legal certificate	
11	Copy of Id card	
12	Copy of PAN	
13	Ambulance Bill with Payment receipt	
14	Policy Copy	
15	Employer Certificate	
16	Nominee certificate	
17	Disability Certificate	

For death cases

18	Death Certificate	
19	Post mortem report	

20	Copy of the legal heir certificate, if the claim is for the death of the principle insured	

As per the policy terms and conditions, the Company reserves its right to have the Insured examined by a doctor appointed by it for verification of diagnosis.

Notes

1. If you are claiming for weekly benefits please ensure you attach evidence of your salary details by providing a certified copy and original of either : 2 x Pay Slips or an Accountant's Statement.
2. If your claim is due to the Accidental Death by Injury of an Insured Person please attach a certified copy of their Death Certificate.
3. Please attach any other information which will assist us in our consideration of your claim.
4. Where there is insufficient space on this claim form to provide a complete answer to a question, please attach your answer on a separate piece of paper and attach it to the claim form. All attachments will form part of the claim form and be subject to the Declaration below.
5. Your Insurance adviser will advise you on where to send this claim form. If you have any doubts, you may contact us on 1800-200-4488

Declaration

I hereby declare that the statements/information given/stated by me/us in this claim form is true, correct and complete.

1. 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 with held or not disclosed.
2. If I 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 & that I shall not be entitled to all/any rights to recover there under in respect of any or all claims, past, present or future.
3. 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 in respect of the claim.
4. I also consent and authorize the Care health insurance limited & third party administrator to seek medical information from any hospital/medical practitioner who has at any time attended on me.
   I/We hereby declare that the particulars made by the insured person in the claim from are true to the best of our knowledge and belief.

Date : __ __ / __ __ / __ __ __ __ (DD/MM/YYYY) Signature of Claimant : ____________________

Place : ____________________

Employer's Declaration

This is to certify that Mr. / Ms. ____________________

working as ____________________ Permanent employee ID No. __________

covered under Group Secure Policy No. ____________________ has been unable to attend his/her occupation

as a result of Injury from ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) to ☐☐ / ☐☐ / ☐☐☐☐

Sum Insured _____

He/she has been employed since _____

Has a claim for Worker's Compensation been lodged? ☐ Yes ☐ No

The total numbers of employees on permanent rolls as on the date of accident were _____

The above information is true to the best of my knowledge and we agree to provide any further information that may be required.

Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Signature of Authorized Person : _____

Place : _____ Name of Authorized Person : _____

Company Seal :

To be filled by the Attending Physician.

Name of Primary Member :

Date of Birth : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Gender :

Address :

City :

State : Pin Code :

Date when injured was brought to you first : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Diagnosis :

Is the present condition/disability attributable to congenital defect? ☐ Yes ☐ No If yes, please provide details : _____

_____

_____

Nature of the accident and details of injuries sustained : _____

_____

_____

Are the injuries solely due to the accident or traceable to any previous injuries/disease/infirmities? Provide details : _____

_____

Is the Claimant now, or had they at the time of the accident, subject to or suffering from any other injury, illness or disease? ☐ Yes ☐ No

If Yes, please provide full details: _____

Are you satisfied that the injuries were caused in the manner as stated to you and that their appearance is consistent with such statement?

☐ Yes ☐ No

If No, please state reasons : _____

Upon which Dates : (i) Did the injury occur begin : _____

(ii) Claimant become totally unable to attend to his/her usual business or occupation : ☐ Yes ☐ No

Was injured/deceased under the influence of intoxicants or drugs at the time of accident? ☐ Yes ☐ No If yes, please provide details of

diagnosis done and alcohol content : _____

How long have you been the patient's usual doctor/medical practice?_____

Was the patient referred by you or to you? _____

If Yes, please provide details of referring doctor

Doctor's Name :

Qualification :

Registration No. :

Address :

City :

State :

Pin Code :

Landline : -

Mobile :

E-mail :

Is the patient still disabled? Yes No If No, when did the patient return to work? _____

If Yes, how long will the patient be Totally disabled (unable to perform any part of their occupation)

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

Partially disabled (able to perform part of their occupation)

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

If partially disabled, what duties could the patient perform and for how many hours a week? _____

Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, Workers Compensation insurer, Social Security, sports body or any other insurance body? Yes No

If Yes, give details : _____

Name of Company and Claim No : _____

Contact Name and Telephone No.: _____

Remarks : _____

If available please provide a copy of X-Ray report

I hereby declare that the information furnished in this claim form is true and correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any relevant fact, right to claim under this claim shall be forfeited. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Doctor's Name :

Qualification :

Registration No. :

Address :

City :

State :

Pin Code :

Landline : -

Mobile :

E-mail :

Date : / / (DD/MM/YYYY)

Doctor's Seal and Signature :

Place : _____

To be completed by nominee in the event of insured's death.

Name of Primary Member :

Date of Birth : / / (DD/MM/YYYY)

Relationship with Claimant :

Gender :

Address :

City :

State : Pin Code :

Landline : - Mobile :

E-mail :

If nominee is minor, kindly provide the Legal Guardian details.

Name of Primary Member :

Date of Birth : / / (DD/MM/YYYY)

Gender :

Address :

City :

State : Pin Code :

Landline : - Mobile :

E-mail :

I/We hereby declare and warrant the truth of the foregoing particulars in every respect. I/We agree that if I/We have made or shall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited.

I/We also hereby declare that I am/we are accepting the amount in full discharge of your obligations under the policy to the Insured Person and/or his/her legal heirs. I/we will hold you indemnified in the event of any claim under this policy being made against you by any other person or persons.

Date : / / (DD/MM/YYYY)

Signature of Nominee/Legal Guardian : _____

Place : _____

Name of Nominee/Legal Guardian : _____