VECTOR BORNE DISEASE COVER – GROUP

CLAIM FORM

Issuance of this form does not amount to 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 the Insured Person/Claimant or anyone acting on behalf of the Insured Person, then the benefits under this policy shall be void and all benefits payable under it shall be forfeited.

POLICY DETAILS

Master Policy Number	
Claim Number	
Name of Proposer	
Certificate of Insurance Number	
Period of Insurance	

TYPE OF BENEFIT CLAIMED

A. **Main Benefit** - Vector Borne Disease ☐

Please select (√) appropriate name of the disease for which claim is submitted

1. Dengue		2. Malaria		3. Filaria (Lymphatic Filariasis)		4. Kala- Azar	
5. Chickungunya		6. Japanese Encephalitis		7. Zika Virus			

B. **Optional Covers**:

Please confirm if any of the benefit is opted under the policy

a. Daily Hospital Cash ☐
b. Recovery Benefit ☐
c. Reinstatement Benefit ☐
d. Increased Waiting Period ☐

DETAILS OF INSURED / CLAIMANT

Name of the Claimant	

DETAILS OF INSURED / CLAIMANT

Relationship with the insured	
Date of Birth	
Gender	
Address	
Contact Details	

Description	Details
Date of first consultation:	DD / MM / YYYY
Name of hospital first consulted for the illness:	
Contact number of doctor / hospitals first consulted for illness:	
Date of disease first detected:	DD / MM / YYYY
Name of Pathology laboratory/Hospital, where disease first diagnosed:	

DETAILS OF HOSPITALIZATION

Name of the Hospital:	
Address & contact No of Hospital:	
OP Number / Hospital No / Indoor Patient No.:	
Date of Admission:	DD / MM / YYYY
Date of Discharge:	DD / MM / YYYY
Name of Treating Doctor:	
Qualification:	
Progress:	Recovered ☐ Death ☐ Improved ☐ Not Improved ☐ Retrogressed ☐
In case of death, please mention date of death:	DD / MM / YYYY

- Have you ever had the similar condition in past? (Yes) / (No)

If 'Yes', provide details_____

DETAILS OF PREVIOUS CLAIM

Have you incurred any claim before? (Yes) / (No)

If Yes, Provide below details:

Name of Insurer:	
Date of claim:	DD / MM / YYYY
Claim No:	
Nature of Claim (Disease Name)	
Claim status:	
Claim Amount:	

BANK ACCOUNT DETAILS

Name of Account Holder	
Cheque No	
Bank Name	
Branch Name	
Cheque Date	
Name as in Bank Account	
Bank Account No	
IFSC Code	
MICR Code	

*In case of minor nominee, please provide details of nominee's joint account with appointee/legal guardian

*Please provide, cancelled cheque/front page of bank passbook/account statement clearly showing above mentioned details (cheque without account holder's name printed are not accepted)

NOMINEE DETAILS

In the event of death of the Insured Person any payment due under the policy shall become payable to the nominee in accordance with the policy terms and conditions. Nominee must be an immediate relative (Mother, Father, Spouse, Son, and Daughter) of proposer.

Name	Date of Birth	Age	Relationship with Proposer
	DD / MM / YYYY		

If the Nominee is minor, please fill the details in Annexure-I

LIST OF DOCUMENTS ENCLOSED

Please tick (√)

1. Duly filled and signed claim form ☐
2. Certified copy of Hospital discharge Summary ☐
3. Certified copy of Diagnostic report confirming diagnosis. ☐
4. Certified copy of final hospital bill ☐
5. Beneficiary name confirmation from Proposer ☐
6. Self-attested Copy of PAN card & Aadhar card, photo id & address Proof of the nominee / beneficiary (Driving license / Passport / Election Card, etc) for address mentioned in claim form ☐
7. Beneficiary bank account / NEFT details: (Cancelled cheque or copy of first page of bank passbook showing account holder's name, Account number, IFSC code, Branch name etc.) ☐
8. Certified copy of Death certificate issued by municipal authority (in case of death of insured) ☐
9. KYC details and Documents ☐

DECLARATION

I/We, the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect; and I/We agree that if I/We have made, or make in any further declaration, the Company may require in respect of the said accident, any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited, and the Policy shall be null and void, and all rights to recover there under in respect of past or future loss/accident shall be forfeited.

Name of Insured/Claimant_____ Signature_____

Place_____

Date DD MM YYYY

Annexure I: TO BE COMPLETED IF NOMINEE IS MINOR

∗ If nominee is minor, kindly provide the Appointee/Legal Guardian details

Name of Guardian

_____

Relationship with nominee _____Date of Birth DD MM YYYY

Address: _____

_____

Contact Details: Phone Number_____ Mobile Number_____

Email ID _____

*Please submit appropriate evidence of legal guardianship

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.

Place_____ Signature _____

Date DD MM YYYY

Annexure II – Medical Certificate to be filled by Treating doctor/Hospital Authority

Name of Hospital:	
Address:	
Contact Details:	
Name of Patient:	
Gender:	Female ☐ Male ☐ Others ☐
Date of Birth:	DD / MM / YYYY Age:
Address:	
Hospital admission No:	
Date of Admission:	DD / MM / YYYY
Date of Discharge:	DD / MM / YYYY
Diagnosis:	
Nature of presenting complaints:	
Date of consent/duration of complaints:	DD / MM / YYYY
Date of first consultation:	DD / MM / YYYY
Date of First Diagnosis:	DD / MM / YYYY

Was this sole reason requiring hospitalization of insured?

If 'No', please provide details:

Nature of diagnostic reports:

Condition at discharge:

I certify that I have examined & treated the above-named Insured, the above statements are correct, and that the hospitalization was a necessity for above mentioned treatment.

Name of Treating Doctor:	
Qualifications:	
Address:	
Contact telephone/mobile No:	
Signature:	
Date:	DD / MM / YYYY