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
Unit No. 604 - 607, 6th Floor, Tower C,
Unitech Cyber Park, Sector-39, Gurugram -122001 (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 (Formerly known as Religare Health Insurance Company 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 (Formerly known as Religare Health Insurance Company 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 (Formerly known as Religare Health Insurance Company Limited) or any factor beyond the control of Care Health Insurance Limited (Formerly known as Religare Health Insurance Company Limited).

Care Health Insurance Limited (Formerly Religare Health Insurance Company Limited)
Registered Office: 5th Floor, 19 Chawla House,Nehru Place,New Delhi-110019 Corresp. Office: Unit No. 604 - 607, 6th Floor, Tower C, Unitech Cyber Park, Sector-39, Gurugram -122001 (Haryana)
Website: www.careinsurance.com E-mail: customerfirst@careinsurance.com Call us: 1800-102-4488
CIN: U66000DL2007PLC161503 UIN: IRDAI/HLT/RHI/P-T/V.I/53/14-15 IRDAI Registration No. - 148

Claim Form - ' group explorē '

Please Note:

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

Policy No. :

Insured Name :

Certificate of Insurance No. :

Section B - Details of Insured Person / Claimant (in Case of Insured's Death)

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

Address :

City : State :

Country : Pin Code :

Landline : - Mobile :

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:-

Medical Cover

In-Patient care for Injury (accident) ☐ In-Patient Care ☐ Day care Treatment ☐

Optional Extensions to Medical Cover :-

Pre-Existing Disease Cover In Life Threatening Medical Condition ☐ Maternity ☐

Extended Cover in the Country of Residence / City of Residence ☐ HIV/AIDS Cover ☐

Treatment of Mental & Nervous Disorder ☐ Drug and Alcohol Abuse ☐

Self-Inflicted Injury ☐ Maternity Complications ☐ Adventure Sports Injury ☐

Corporate Floater ☐ Recharge of Sum Insured ☐

Out-patient Cover

Out-Patient care for Injury(accident) ☐ Out-Patient Care ☐

Optional Extensions to Out-patient Cover :-

Pre-Existing Disease Cover In Life Threatening Medical Condition ☐ Treatment of Mental & Nervous Disorder ☐

Radiotherapy and Chemotherapy Charges ☐ Vaccination Charges ☐

Cancer screening & Mammography ☐ Adventure Sports Injury ☐ Non-emergency OPD consultation ☐

Medical Evacuation ☐ **Dental expenses** ☐ **Maternity Cash Benefit** ☐

Daily Allowance ☐ **Home Care** ☐ **Non-Allopathic Treatments** ☐

Health Check-up ☐

Name, address and telephone number of Hospital where treatment was given: _____

_____

Name of treating doctor/dental surgeon: _____

Details of Illness/Injury: _____

_____

Cause of the Illness/Injury: _____

_____

Was the Illness/incident caused/ aggravated due to a pre-existing condition? Please give details: _____

_____

Date of onset of Illness (DDMMYYYY) : | | | | | | | | |

Nature of treatment: _____

_____

_____

Date of treatment (DDMMYYYY) : From | | | | | | | | | To | | | | | | | | |

Reason for Medical Evacuation (If Medical Evacuation)_____

_____

Medical Evacuation From: _____ To _____ Date : | | | | | | | | |

Serial No.	Expense Details	Amount(Rs)

Repatriation of Mortal Remains ☐

Cause of death: _____

Date of death of Insured (DDMMYYYY): | | | | | | | | | Total expenses _____

Transportation From: _____ To _____ Date : | | | | | | | | |

Loss of Checked-in Baggage ☐ **Delay of Checked-in Baggage** ☐

Name of Common Carrier_____

In case of loss of checked-in Baggage

Date of loss (DDMMYYYY) : | | | | | | | | | Place of loss: _____

In case of delay of checked-in Baggage

Date and time of arrival date : | | | | | | | | | Time (HHMM): | | | | | | | | |

Port of disembarkation: _____

Date and time of baggage retrieval: Date | | | | | | | | | Time (HHMM): | | | | | | | | |

Serial No.	Expense Details	Amount(Rs)

Loss of Passport ☐ **Emergency Cash Advance** ☐ **Personal Liability** ☐ **Identity Document Theft** ☐

Date of loss (DDMMYYYY) : | | | | | | | | | Place of loss: _____

Detail of loss: _____

_____

Name of aggrieved third party (in case of Personal Liability): _____ Total expenses _____

Personal Accident ☐ **Common Carrier Fatality** ☐

Cause of Accident: _____

_____

Nature of loss/ Injury: _____

_____

Place of Accident: _____ Details of Common Carrier: _____

Name, address and telephone number of hospital/clinic where treatment was given: _____

_____

_____

Name of treating doctor: _____

Date of medical/surgical treatment (DDMMYYYY): From ☐☐☐☐☐☐☐☐ To ☐☐☐☐☐☐☐☐

Date of death (DDMMYYYY) : ☐☐☐☐☐☐☐☐

Hijack Distress Allowance ☐

Name of Common Carrier: _____

Port of Hijack: _____ Port of release: _____

Date of Hijack (DDMMYYYY) : From ☐☐☐☐☐☐☐☐ To ☐☐☐☐☐☐☐☐

Time of Hijack (HHMM) : From ☐☐☐☐ To ☐☐☐☐

Trip Cancellation ☐ **Trip Interruption** ☐ **Trip Delay** ☐

Missed Connection ☐ **Hotel Cancellation** ☐ **Bounce Booking** ☐

Name of Common Carrier /Hotel : _____

Scheduled departure: Date (DDMMYYYY) ☐☐☐☐☐☐☐☐ Time (HHMM) ☐☐☐☐☐☐☐☐

Scheduled arrival: Date (DDMMYYYY) ☐☐☐☐☐☐☐☐ Time (HHMM) ☐☐☐☐☐☐☐☐

Common Carrier route : From: _____ To _____

Name of Common Carrier /Hotel : _____

Actual departure: Date (DDMMYYYY) ☐☐☐☐☐☐☐☐ Time (HHMM) ☐☐☐☐☐☐☐☐

Actual arrival: Date (DDMMYYYY) ☐☐☐☐☐☐☐☐ Time (HHMM) ☐☐☐☐☐☐☐☐

Common Carrier route : From: _____ To _____

For Missed Connection only :-

Name of Connecting Common Carrier : _____

Connecting Common Carrier route : From: _____ To _____

Scheduled departure: Date (DDMMYYYY) ☐☐☐☐☐☐☐☐ Time (HHMM) ☐☐☐☐☐☐☐☐

Description of incident : _____

Total expenses _____

Up-gradation to Business Class ☐

Name, address and telephone number of hospital/clinic where treatment was given: _____

_____

Name of treating doctor: _____

Details of the Injury: _____

_____

Date of Hospitalization (DDMMYYYY): From: ☐☐☐☐☐☐☐☐ To ☐☐☐☐☐☐☐☐

Details of journey : From: _____ To _____

Date : ☐☐☐☐☐☐☐☐ Total expenses _____

Compassionate Visit ☐ **Return of Minor Child** ☐ **Replacement of Staff** ☐ **Parent Accommodation** ☐

Name, address and telephone number of hospital/clinic where treatment was given: _____

_____

Name of treating doctor: _____

Details of Illness: _____

_____

Cause of the Illness: _____

_____

Nature of treatment: _____

_____

Date of Hospitalization (DDMMYYYY) : ☐☐☐☐☐☐☐☐

Treating doctor's opinion on how many more days the patient will need to be hospitalized: ☐☐☐☐☐☐☐☐

Treating doctor's opinion on why the patient cannot be sent back to Country of Residence for further treatment:_____

_____

Treating doctor's opinion on need for an attendant: _____

Details of journey: From _____ To: _____

Total expenses _____

Emergency Hotel Accommodation / Extension ☐

Name of hotel: _____

Booking date (DDMMYYYY) : ☐☐☐☐☐☐☐☐ Confirmation date: ☐☐☐☐☐☐☐☐

Reason for emergency hotel accommodation / extension: _____

_____

Total expenses _____

Spectacles Damage ☐

Loss date : ☐☐☐☐☐☐☐☐

Cause of damage: _____

Description of item damaged: _____ Total expenses _____

Re-imbursement of Golf Fees ☐

Loss date : ☐☐☐☐☐☐☐☐

Reason for loss: _____

_____

Details of expenses incurred: _____

Total expenses _____

Political Risk and Catastrophe Evacuation ☐

Date of evacuation : ☐☐☐☐☐☐☐☐

Reason for Evacuation: _____

_____

Total expenses _____

Loss of Laptop / Tablet / Hand baggage ☐

Loss date : ☐☐☐☐☐☐☐☐

Reason for loss: _____

_____

Details of expenses incurred: _____

Total expenses _____

Bail Bond ☐

Name and contact details of the detaining authority: _____

The offence for which Insured is in custody: _____

Is this offence bailable as per the laws of the detaining country?: Yes ☐ No ☐

Total expenses _____

Sponsor Protection ☐

Name of the sponsor:

_____

Cause of accident causing demise of the sponsor: _____

_____

Nature of Injury causing the demise of the sponsor: _____

_____

Place of accident of the sponsor: _____

Name, address and telephone number of hospital/clinic where treatment was given to the sponsor:_____

_____

Name of treating doctor of the sponsor: _____

Details of medical/surgical treatment given to sponsor: _____

_____

Date of medical/surgical treatment (DDMMYYYY) : From ☐☐☐☐☐☐☐☐ To ☐☐☐☐☐☐☐☐

Date of Accidental Death (DDMMYYYY) : ☐☐☐☐☐☐☐☐

Study Interruption ☐

Due to Hospitalization of the Insured ☐

Name, address and telephone number of hospital/clinic where treatment is being given:_____

Name of treating doctor: _____

Details of Illness: _____

_____

Cause of the Illness: _____

_____

Nature of treatment: _____

Dates of Hospitalization (DDMMYYYY) : From ☐☐☐☐☐☐☐☐ To ☐☐☐☐☐☐☐☐

Reason for medical evacuation (if applicable): _____

Reason for not continuing studies abroad: _____

Tuition Fees paid in advance for the year : ☐☐☐☐☐☐☐☐

Due to death of immediate family member ☐

Name of the immediate family member: _____

Cause of accident causing demise of the immediate family member: _____

_____

Nature of Injury causing the demise of the immediate family member: _____

_____

Place of accident of the immediate family member: _____

Name, address and telephone number of hospital/clinic where treatment was given to the immediate family member:_____

_____

Name of treating doctor of the immediate family member:_____

Details of medical/surgical treatment given to immediate family member: _____

_____

Dates of medical/surgical treatment (DDMMYYYY): From ☐☐☐☐☐☐☐☐ To ☐☐☐☐☐☐☐☐

Reason for not continuing studies abroad: _____

Tuition Fees paid in advance for the year : ☐☐☐☐☐☐☐☐

University Insolvency ☐

Name of the University: _____

FIR / Complaint date and Number: _____

Details of expenses incurred: _____

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 (Formerly known as Religare Health Insurance Company 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

Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Signature of the Claimant : _____

Place : _____