

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.

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	S No.	Type of Document	Tick
1	Duly filled and signed claim form		10	Copy of the medico-legal certificate	
2	Hospital Payment Receipt		11	Copy of Id card	
3	Pharmacy Bills		12	Copy of PAN	
4	Investigation Reports/Reports Name		13	Ambulance Bill with Payment receipt	
5	Discharge Summary		14	Policy Copy	
6	Operation theater notes		15	Employer Certificate	
7	Hospital Main Bill		16	Nominee certificate	
8	Copy of First Information Report (FIR)		17	Disability Certificate	
9	Hospital Breakup Bill				

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 withheld 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 form 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

Care Health Insurance Limited
Registered Office: 5th Floor, 106

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 :

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 :

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 : _____