ACKO GROUP HEALTH INSURANCE POLICY

CLAIM FORM

NOTE: The submission of this Claim Form is not to be taken as an admission of liability by Acko General Insurance Ltd.

Please complete this form in CAPITAL LETTERS completely and sign the same. Please do not leave any column unanswered. Mention "N/A", if not applicable.

Section I – To be completed by Insured Person/" Claimant"

I. DETAILS OF POLICYHOLDER:

- Group Name: _____
- Policy No: _____
- Name: _____ Type of Business: _____
- Address: _____
  City: _____ State: _____ Pin Code: _____
- Telephone Number: Mobile: _____ Office (*Optional*): _____
  E-mail: _____ Date of Birth: DD/MM/YYYY

II. DETAILS OF INSURANCE HISTORY:

- Currently covered by any other Health/Travel Insurance Policy (Y/N): ___
- Date of commencement of first Insurance without break: DD/MM/YYYY
- If yes, Company Name: _____
  Policy No. and Sum Insured: _____
- Have you been hospitalised in the last four years since inception of the contract (Y/N): ___
  Diagnosis: _____
- Previously covered by any other Health/Travel Insurance (Y/N): ___
- If yes, Company Name: _____

III. DETAILS OF THE INSURED PERSON IN RESPECT OF WHOM CLAIM IS MADE:

- Name of Primary Insured: _____
- Name of claimant: _____ Occupation: _____
- Relationship with Policyholder: _____
- Address: _____
  City: _____State: _____ Pin Code: _____
- Telephone Number: Mobile: _____ Office (Optional): _____
- E-mail: _____ Date of Birth: DD/MM/YYYY
- Certificate of Insurance No: _____
- Mode of Travel: _____
- Date of Injury/Death: DD/MM/YYYY Time: HH:MM hrs
- Place of Accident/Injury/Death: _____
- Details of Accident and Nature of Accident:
  _____
  _____
- Details of Loss (Date & Location):
  _____
  _____

- Details of Inconvenience:
  _____
  _____
- Details of Liability Claim:
  _____
  _____
- Did the Accident/ Loss/ Inconvenience happen when Insured Person was travelling in the covered mode of travel: Yes ___ No ___
- Whether reported to Police: Yes ___ No ____
  (If Yes, Name and Address of Police Station): _____
- _____ If No, Give reasons: _____
  _____
- First Information Report (FIR)/ Medico Legal Certificate (MLC)/ Missing complaint No.
  _____ Date: DD/MM/YYYY
- Contact Details of Police Station: _____

IV. TRAVEL DETAILS

- Name of the Carrier: _____
- Unique Identification of Travel _____ (Ex. PNR, Flight No, etc.)
- Mode of Travel: _____
- Scheduled Departure & Arrival: _____
- Actual Departure & Arrival: _____

V. DETAILS OF HOSPITALIZATION:

- Name and Address of the Hospital: _____
- Room Category occupied: _____
- Hospitalization due to: _____
- Date of injury/Date disease first detected/Date of Delivery: _____
- Date of Admission: DD/MM/YYYY Time: HH:MM hrs
- Date of Discharge: DD/MM/YYYY Time: HH:MM hrs
- System of Medicine (Allopathic/AYUSH): _____

VI. DETAILS OF WITNESSES (IN CASE OF ACCIDENT):

- Was there any witness to the Accident: Yes ___ No ____
  (If Yes, complete the following)
- Name: _____
- Address: _____
  City: _____State: _____ Pin Code: _____
- Telephone Number: Mobile: _____ Office (Optional): _____

- Note: *Please attach all original witness statements if already obtained.*

VII. DETAILS OF BENEFITS CLAIMED:

Sr. No.	Name of Benefit/Add-on Benefit	Amount Claimed
1	In-Patient Hospitalization Cover	
2	Worldwide In-Patient Hospitalization Cover	
3	In-Patient Hospitalization Fixed Benefit	
4	Hospital daily Cash	
5	Day Care Treatment Cover	
6	Road Ambulance	
7	Compassionate Visit	
8	Compassionate Visit Stay	
9	Loss of Pay due to Hospitalization	
10	EMI Protection	
11	Missed Bill Payment	
12	Hardship Allowance	
13	Income Protection Cover	
14	Maternity	
15	New Born Baby Medical Expenses	
16	Pre-Post Natal	
17	Vaccination	
18	Repatriation of Mortal Remains	
19	Funeral Expenses	
20	Room Rent Limits / Room Type Options	
21	ICU Limits	
22	Pre and Post Hospitalization Medical Expense Cover	
23	Sleep Apnea Cover	
24	Septoplasty Cover	
25	Gender Affirmation/ Reassignment Surgery Cover	
26	Well Baby Cover	
27	No Active Line of Treatment Cover	
28	Domiciliary Treatment Cover	
29	Donor Expenses	
30	Daily Cash for choosing lower category room	
31	Sub-Limits for Specific Condition	
32	Restoration of Sum Insured	
33	Cumulative Bonus	
34	Additional Buffer Sum Insured for the Group	
35	Annual Aggregate Deductible	
36	Per Claim Deductible	
37	Group Deductible	
38	Reimbursement Only Cover	
39	First notification of claim (FNOC) Cover	
40	Network limited to specified geographies	
41	Network limited to preferred providers	
42	Coverage Continuity in case of Pink Slip	
43	Rewards for Healthy Behaviour	
44	Expert Opinion	
45	Healthy Pregnancy Program	
46	Child Protect Cover	

Sr. No.	Name of Benefit/Add-on Benefit	Amount Claimed
47	Accidental Death Benefit	
48	Permanent Total Disability	
49	Permanent Partial Disability	
50	Temporary Total Disability	
51	Child Education Cover	
52	Disappearance Cover	
53	Loan Protector	
54	Outstanding Bills Protection Benefit	
55	Convenient Travel Option	
56	Modification of Vehicle/Home	
57	Chauffer Benefit	
58	Personal Accident (Common Carrier)	
59	Additional Permanent Total Disability	
60	Additional Temporary Total Disability	
61	Critical Illness Cover	
62	Critical Illness Benefit Waiting Period	
63	Survival Period for Critical Illness	
64	Trip Delay	
65	Trip Cancellation & Interruption	
66	Trip Curtailment	
67	Delay of Checked-in Baggage	
68	Loss of Checked-in Baggage	
69	Loss of Baggage and Personal Effects	
70	Personal Liability	
71	Financial Emergency Cash	
72	Kidnap / Ransom / Extortion Coverage	
73	Carrier Cancellation	
74	Cancellation of Carrier by Insured Person	
75	Denied Boarding - Carrier	
76	Missed Carrier	
77	Missed Event	
78	Missed Connection	
79	Fare Lock	
80	Fare Dip	
81	Electronic Equipment Cover	
82	Denied Hotel Accommodation	
83	Emergency Hotel Requirement	
84	Home Insurance Cover	
85	Fire and Allied Perils (Home Building & Contents)	
86	Travel with Pet Cover	
87	Out-Patient Treatment Cover (OPD)	
88	Dental Cover	
89	Vision Expenses Cover	
90	LASIK	
91	Preventive Health Check-up	
92	Prescribed Diagnostics	
93	Domestic Emergency Evacuation	
94	International Emergency Evacuation	

Sr. No.	Name of Benefit/Add-on Benefit	Amount Claimed
95	Medical Equipment Cover	

VIII. DOCUMENTS REQUIRED FOR SUBMISSION OF CLAIM:

i. Copies of valid KYC documents of the Nominee/claimant (such as Passport/ PAN Card/Aadhar number etc);
ii. Legal heir certificate, in the event of death where the Nominee is also deceased or information about the Nominee has not been provided by the proposer at the time of policy issuance.
iii. Copy of FIR/MLC
iv. Hospital main bill, break-up bill, bill payment receipt, discharge summary, operation theatre notes, Doctor's request for investigation
v. Death Certificate attested by issuing/ appropriate authority.
vi. Leave certificate from the employer (Hospitalization claims)
vii. Name and address of the attending Medical Practitioner
viii. Medical reports, case histories, investigation reports, treatment papers as applicable
ix. Discharge summary/certificate
x. Certification of disability along with percentage of disability/ Photograph of the injured with reflecting disablement (if applicable);
xi. Travel Tickets
xii. Proof of Loss/ Inconvenience provided by the travel organizer/ service provider
xiii. Ownership proof/ invoice of lost item
xiv. Any other information relevant to the Injury/Hospitalization/illness
xv. Additional documents depending on the nature of the claim will be requested as and when required (if applicable)

IX. DETAILS OF BANK ACCOUNT FOR CLAIM PAYMENT:

Please furnish the details below along with copy of cancelled cheque.

- Bank Name: _____
- Bank Branch: _____
- Bank Account Number: _____
- IFSC Code: _____ MICR Code: _____

X. DECLARATION:

I hereby declare that the information furnished in this claim form is true, complete and accurate to the best of my knowledge and belief. If I have made any false or untrue statement, or I have suppressed or concealed any material fact with respect to questions asked in relation to this claim, my right to claim any benefits under the Policy shall be forfeited.

I also consent and authorize Acko General Insurance Ltd, to seek necessary medical information / documents from any Hospital / Medical Practitioner/ Travel Organiser/ Service Provider who has attended on the person against whom this claim is made.

Date: DD/MM/YYYY Signature of Claimant: _____
Place: _____

XI. DIRECT FUND TRANSFER / EFT MANDATE FORM:

(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.)

A) Would you like to opt for Electronic Fund Transfer as mode of payment? Yes No
B) If Yes, kindly provide the below mentioned details:
Payee Name (as per bank records): _____
Payee Account No.: _____
Type of Account: _____
Name of the Bank: _____ Branch Name: _____
Address of the Bank: _____
IFSC Code of the Bank: _____ MICR Code No. of the Bank: _____

Permanent Account Number (PAN) of Payee:
1. Please attach an ORIGINAL BLANK CANCELLED CHEQUE signed by the Payee.
2. Please attach a PAN CARD copy of Payee.

Terms and conditions for payment through RTGS / NEFT

1. The details provided by the Customers in the Mandate Form shall be considered as final and Acko General Insurance Ltd. shall not be responsible for cross verification of any of the details provided therein.
2. The RTGS / NEFT facility shall be effective for the respective Customer(s) within 15 days of the receipt of the Mandate Form by Acko General Insurance Ltd. and or within such period as may be reasonably required by Acko General Insurance Ltd. to activate the RTGS / NEFT facility.
3. The customer agrees that under the RTGS / NEFT facility, there may be a risk of non-payment in the Account of Customer 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 Acko General Insurance or any factor beyond the control of Acko General Insurance Limited.
4. The customer agrees to indemnify, without delay or demur, Acko General Insurance Ltd. and its agents and keep Acko General Insurance Ltd. and its agent indemnified harmless at all times from and against any and all claims, damages, losses, costs, and expenses (including attorney's fees) which Acko General Insurance Ltd. may suffer or incur, directly or indirectly, arising from or in connection with, amongst offer things, either of the aforesaid reasons stated in above clauses.
5 .Acko General Insurance Ltd. may sub-contract and employ agents to carry out any of its obligations under the RTGS / NEFT facility. The Customer may discontinue or terminate the use of RTGS / NEFT facility by giving a minimum of 15 days prior written notice to Acko General Insurance Ltd. The date of notice for Acko will be the date of receipt of such notice by Acko. The notice of such termination should be given to Acko only at its corporate address and be addressed at Acko General Insurance Ltd. F 2nd Floor, #36/5, Hustlehub One East, Somasandrapalya, 27th Main Rd, Sector 2, HSR Layout, Bengaluru, Karnataka, 560102. A confirmation of the receipt of termination notice given by the Customer will be acknowledged through a confirmation letter by Acko General Insurance Ltd. In no case can the Customer construe his termination notice as effective unless a confirmation has been provided by Acko to the Customer stating the date of receipt of such communication by the Customer.
7. The Customer agrees that transaction(s) through RTGS / NEFT facility may attract inward RTGS / NEFT charges, which if levied by the Customer's bank, shall be borne by the Customer.
8. Acko has the absolute discretion to amend or supplement any Terms and Conditions stated herein at any time and will endeavour to give prior notice of Ten days for such changes wherever feasible for the terms and conditions to be applicable. By using the new services, or at the completion of such period, whichever is earlier, the customers shall be deemed to have accepted the changes terms and conditions.

9. 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.
10. Notices under these terms and conditions may be given in writing by delivering them by hand or e-mail or on Acko General Insurance Ltd. website www.acko.com or by sending them by post to the last address of the Customer.
11. These terms and conditions will be governed by the laws of India and any legal action or proceedings arising out of these Terms and Conditions shall be initiated in the courts or tribunals at Mumbai in India.

Date: DD/MM/YYYY
Place: _____

Signature of Claimant: _____

CLAIM FORM PART – B

NOTE: The submission of this Claim Form is not to be taken as an admission of liability by Acko General Insurance Ltd.

Please complete this form in CAPITAL LETTERS completely and sign the same. Please do not leave any column unanswered. Mention "N/A", if not applicable.

Section I – To be completed by the Hospital

I. DETAILS OF HOSPITAL:

- Name of the Hospital: _____
- Hospital ID: _____
- Type of Hospital: _____
- Name of the treating doctor: _____
- Qualification: _____
- Registration No. with State Code: _____
- Telephone Number: Mobile: _____ Office (*Optional*): _____

II. DETAILS OF PATIENT ADMITTED:

- Name of the Patient: _____
- IP Registration No.: _____
- Gender (M / F): _____ Age (YY/MM): _____ Date of Birth (DD/MM/YYYY): _____
- Date of Admission: DD/MM/YYYY Time: HH:MM hrs
- Date of Discharge: DD/MM/YYYY Time: HH:MM hrs
- Type of admission: Emergency _____ Planned _____ Day Care _____ Maternity _____
- If Maternity: Date of Delivery: DD/MM/YYYY _____ Gravida Status: _____
- Status at time of discharge: Discharge to home ___ Discharge to another hospital ___ Deceased ___
- Total Claimed Amount: _____

III. DETAILS OF AILMENT DIAGNOSED (PRIMARY):

- Primary Diagnosis: ICD 10 Code _____ Description _____
- Additional Diagnosis: ICD 10 Code _____ Description _____
- Co-morbidities: ICD 10 Code _____ Description _____
- Co-morbidities: ICD 10 Code _____ Description _____
- Procedure 1: ICD 10 Code _____ Description _____
- Procedure 2: ICD 10 Code _____ Description _____
- Procedure 3: ICD 10 Code _____ Description _____
- Details of Procedure: _____
- Present ailment is a complication of PED: _____
- If yes, specify details: _____
- Pre-authorization obtained: Yes ___ No ____
- Pre-authorization No.: _____
- If authorization by network hospital not obtained, give reason: _____
- Hospitalization due to: _____
- If injury give cause (Y/N): Self Inflicted ___ Road Traffic Accident ___ Substance Abuse/Alcohol ___
- If Medico Legal (Y/N): ___ Reported to Police (Y/N): ___ MLC Report and FIR attached (Y/N): ___

- If not reported to Police, give reason: _____

IV. DOCUMENTS REQUIRED FOR SUBMISSION OF CLAIM:

i. Hospital main bill, break-up bill, bill payment receipt, discharge summary, operation theatre notes, Doctor's request for investigation
ii. Medical reports, case histories, investigation reports, treatment papers as applicable
iii. Discharge summary/certificate
iv. ECG
v. Pharmacy Bills
vi. Copy of FIR/MLC
vii. Any other information relevant to the Injury/Hospitalization
viii. Additional documents depending on the nature of the claim will be requested as and when required (if applicable)

V. ADDITIONAL DETAILS IN CASE OF NON-NETWORK HOSPITAL ONLY:

- Address of the Hospital: _____
  _____
  City: _____State: _____ Pin Code: _____
- Telephone Number: Mobile: _____ Office (Optional): _____
- E-mail: _____ Date of Birth: DD/MM/YYYY
- Registration No. with State Code: _____
- Hospital PAN: _____
- No. of in-patient beds: ____
- Facilities available in the Hospital: OT: Yes ___ No ____ ICU: Yes ___ No ____
  Others: _____

VI. DECLARATION BY THE HOSPITAL:

We hereby declare that the information furnished in this claim form is true, complete and accurate to the best of our knowledge and belief. If we have made any false or untrue statement, or we have suppressed or concealed any material fact with respect to questions asked in relation to this claim, our right to claim under this claim shall be forfeited.

Date: DD/MM/YYYY Signature and Seal of the Hospital Authority: _____
Place: _____