Edelweiss | GENERAL INSURANCE

EDELWEISS GROUP TOTAL PROTECT POLICY - CLAIM FORM

Toll Free 1800 12000

Instructions:
1. This form should be filled in by the insured person/claimant
2. Issuance of this form does not imply acceptance of liability
3. Please fill all the details in BLOCK LETTERS
4. All fields in this form are mandatory
5. If there is any other information to be provided, please write the same in a separate sheet, sign the sheet and attach it to this form

SECTION A – DETAILS OF INSURED PERSON

a) Master Policy No.: | | | | | | | | | | | b) Certificate No.: | | | | | | | | | | |

c) Company/TPA/ASP/Policyholder issued ID card no.: | | | | | | | | | | | | | | | | | | | | | |

d) Name of Insured Person: _____ e) Photo identity proof: _____

f) Passport Number: (wherever applicable) _____

g) Address as per photo identity proof: _____

City: _____ State: _____ Country: _____ Landmark: _____

Date of Joining/Associating: D D M M Y Y Y Y Postal Code: _____

Phone Number: | | | | | | | | | | Email: _____

h) Name of Company (if applicable): _____ Employee No.: _____ Branch Location: _____

SECTION B – DETAILS OF INSURED PERSON/CLAIMANT CLAIMING FOR COVERAGE UNDER THE POLICY

a) Name of the Insured Person/ Claimant: _____

b) Photo Identity Card Number: _____

c) Gender: Male ☐ Female ☐ Third Gender ☐

d) Age: Y Y years M M months e) Date of Birth: D D M M Y Y Y Y

f) Relationship with Primarily Insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please Specify) ☐

g) Occupation: Service Self-employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please Specify) ☐

h) Current Residential Address (if different from above) _____

City: _____ State: _____ Country: _____ Postal Code: _____

Phone Number: | | | | | | | | | | Email: _____

i) Loan Details: Loan A/c no: | | | | | | | | | | | | | | | | |

Loan Start Date: D D M M Y Y Y Y Tenure: _____ Name of Bank/ Financial Institution _____

Address of Bank / Institution: _____

SECTION C – BENEFIT BEING CLAIMED FOR

Death ☐ Permanent Partial Disability ☐ Permanent Total Disability ☐ Temporary Total Disability ☐

Accidental Hospitalization ☐ Others ☐ (Please Specify) _____

a) Place of Treatment: Within India ☐ Outside India ☐ (Please specify the location): _____

b) Name of Hospital where Hospitalized: _____

Address of the Hospital: _____

Landmark: _____ Country: _____ Town/City: _____ Postal Code: _____

c) Details of the Accident/event: _____

d) Hospitalization due to: Injury ☐ Illness ☐

e) Date of Injury: D D M M Y Y Y Y

f) Date of Admission: D D M M Y Y Y Y g) Date of Discharge: D D M M Y Y Y Y

h) If due to injury, give cause: Self-inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption ☐

i) Medico-legal: (i)Yes ☐ No ☐ (ii) Reported to Police: Yes ☐ No ☐ iii) MLC & FIR attached: Yes ☐ No ☐

j) If claiming for any other benefit, please provide details: _____

SECTION D – DETAILS OF CLAIM

a) Name of benefits claimed with details:

i)	
Total:	₹

Claim Documents Submitted – Checklist

☐ Duly signed Claim Form	☐ Post Mortem Report (if conducted)
☐ Copy of the claim intimation, if any	☐ Inquest Report/Panchnama
☐ Hospital main bill	☐ Coroner's report/forensic science laboratory report (if available)
☐ FIR from police authorities, wherever necessary (in case of accidents outside residence)	☐ Fitness certificate (if available)
☐ Death Certificate from the municipal authorities and Death Summary from hospital authorities	☐ Any other document(s) required for assessment of claim as per benefit opted

SECTION E – DETAILS OF ASSISTANCE SERVICES (Tick the right option)

a) Emergency Medical Evacuation: _____ b) Medical Repatriation: _____

c) Repatriation of Mortal Remains: _____ d) Compassionate (Parental/Spouse Accommodation): _____

SECTION F – DETAILS OF BANK ACCOUNT OF INSURED PERSON/NONIMEE/LEGAL HEIR

e) PAN: | | | | | | | | | | f) Bank Account Number: | | | | | | | | | | | | | | |

g) Bank Name and Branch: _____

h) Cheque/DD Payable details: | | | | | | | | i) IFSC: | | | | | | | | | | | |

SECTION G – DECLARATION BY THE INSURED PERSON/CLAIMANT

(PLEASE READ VERY CAREFULLY)

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppressed or concealed any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize the Company, its authorized TPA and ASP to seek necessary medical information/documents from any hospital/medical practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills/receipts/available documents for the purpose of this claim & that I will not be making any supplementary claim.

Date: | D | D | M | M | Y | Y | Y | Y |

Place: _____

Signature of the Insured /Claimant

Edelweiss General Insurance Company Limited, Corporate Office: 5th Floor, Tower 3, Kohinoor City Mall, Kohinoor City, Kirol Road, Kurla (West), Mumbai- 400070, Registered Office: Edelweiss House, Off CST Road, Kalina, Mumbai-400 098, IRDAI Regn. No.: 159, CIN: U66000MH2016PLC273758, Reach us on: 1800 12000, Email: support@edelweissinsurance.com, Website: www.edelweissinsurance.com, Issuing/Corporate Office: +91 22 4272 2200, Grievance Redressal Officer: +91 22 4931 4422, Dedicated Toll-Free Number for Grievance: 1800 120 216216. Trade logo displayed above belongs to Edelweiss Financial Services Limited and is used by Edelweiss General Insurance Company Limited under license. Insurance is the subject matter of solicitation.