Corona Rakshak Policy, Edelweiss General Insurance Company Limited - Claim Form A

Edelweiss | GENERAL INSURANCE

Toll Free 1800 12000

Need to claim? We're here to make it easy!

Just follow these simple instructions:
1. This form has to be filled in BLOCK letters by the Insured Person / Nominee / Legal Heir
2. This form is not an admission of liability.

SECTION A – ABOUT YOU AND YOUR POLICY

a) Policy No.: | | | | | | | | | | b) Sl. No. / Certificate No.: | | | | | | | | | | |

c) Name: _____

d) Address: _____ Landmark: _____

City: _____ State: _____ Pin Code: | | | | | | |

Phone No.: | | | | | | | | | | Email ID: _____

SECTION B – DETAILS OF YOUR PAST / OTHER INSURANCE

a) Are you currently covered by any other Mediclaim / Health Insurance? Yes ☐ No ☐

b) Date of start of first Insurance without break: D D M M Y Y Y Y

c) If Yes, Company Name: _____ Policy No.: _____ Sum Insured (INR): _____

d) Have you been Hospitalized in the last four years since the start of the contract? Yes ☐ No ☐ Date: M M Y Y

Diagnosis: _____

e) Were you been previously covered by any other Mediclaim / Health Insurance? Yes ☐ No ☐

f) If yes, Company Name: _____

SECTION C – DETAILS OF INSURED PERSON HOSPITALIZED

a) Name: _____

b) Gender: Male ☐ Female ☐ Third Gender ☐ c) Age: ☐☐ Years ☐☐ Months d) Date of Birth: D D M M Y Y Y Y

e) Relationship with Primary Member: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please specify) _____

f) Occupation: Service ☐ Self-employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please specify) _____

g) Address (if different from above): _____

City: _____ State: _____ Pin Code: | | | | | | |

Phone No.: | | | | | | | | | | Email ID: _____

SECTION D – A BIT ABOUT THE PERSON HOSPITALISED

a) Name of Hospital, where Admitted: _____

b) Expenses related to: Hospitalization due to Covid -19 Confirmed Case ☐

c) Date the Disease was first detected: D D M M Y Y Y Y

d) Date of Admission: D D M M Y Y Y Y Time: H H : M M

e) Date of Discharge: D D M M Y Y Y Y Time: H H : M M

SECTION E – ABOUT YOUR CLAIM

a) Details of the benefit being claimed _____

(i) Hospitalization due to Covid-19 Diagnosis as positive: _____

b) The documents we'll need:

- ☐ Signed Claim Form
- ☐ Hospital Main bill
- ☐ Treatment Notes
- ☐ Hospital Discharge card/Summary
- ☐ Copy of the Covid-19 Positive Test Report
- ☐ Investigation Reports, if any
- ☐ Hospital Bill Payment Receipt
- ☐ Any other document, as and when required by the company for assessment of the claim

_____

SECTION F – THE PRIMARY INSURED'S BANK ACCOUNT DETAILS

a) PAN: ☐☐☐☐☐☐☐☐☐☐ b) Account No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c) Bank Name and Branch: _____

d) Cheque / DD Payable Details: ☐☐☐☐☐☐☐ e) IFSC Code: ☐☐☐☐☐☐☐☐☐☐☐

GUIDANCE FOR FILLING CLAIM FORM PART A

(TO BE FILLED BY THE INSURED)

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A – DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) Sl. No / Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) Name	Enter the full name of the policyholder	Surname, First name, Middle name
d) Address	Enter the full postal address	Include street, city and pin code
SECTION B – DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Tell us if the insured person is currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yyyy format
c) Company Name	Enter the full name of the Insurance Company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalised in the last four years since inception of the contract?	Tell us if you've been Hospitalised in the last four years	Tick Yes or No
Date	Enter the date of hospitalization	Use mm-yyyy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Mediclaim / Health Insurance?	Tell us if the insured person was previously covered by another Mediclaim / Health Insurance.	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Tell us the gender of the patient	Tick Male or Female or Third Gender
c) Age	Enter the age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yyyy format
e) Relationship with Primary Member	Tell us the patient's relationship with the policyholder	Tick the right option. If others, please specify.
f) Occupation	Tell us the patient's occupation	Tick the right option. If others, please specify.
g) Address	Enter the full Postal Address	Include Street, City and Pin Code
Phone No	Enter the phone number of patient	Include STD code with telephone number
E-mail ID	Enter the E-mail ID	Enter the E-mail ID
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital, where Admitted	Enter the name of the hospital	Name of hospital in full
b) Expenses related to	Give us details of Hospitalization	Tick the right option
c) Date Disease first detected	Enter the date of the first available Covid-19 positive pathology test report	Use dd-mm-yyyy format
d) Date of Admission	Enter date of admission	Use dd-mm-yyyy format
Time	Enter time of admission	Use hh:mm format
e)Date of Discharge	Enter date of discharge	Use dd-mm-yyyy format
Time	Enter time of discharge	Use hh:mm format

SOME TIPS TO FILL THECLAIM FORM – PART A

SECTION E – DETAILS OF CLAIM		
a) Details of Benefits claimed	Enter the amount claimed	In Rupees (Do not enter paise values)
i) Hospitalization due to Covid-19 Diagnosis as positive	Enter the amount claimed as per the benefit available in your policy	In Rupees (Do not enter paise values)
b) Claim Documents Submitted Check List	Tell us which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) Cheque / DD payable details	Enter the name of the beneficiary the cheque / DD should be made out to	Name of the individual / organization in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full

SECTION G – DECLARATION BY THE INSURED

(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 Insurer, to seek necessary medical information / documents from any hospital / medical practitioner who has treated the person for whom this claim is made. I hereby declare that I have included all the documents for the purpose of this claim & that I will not be making any other claim.

Date: D D M M Y Y Y Y

Place: _____

Signature and stamp of authorized signatory