Edelweiss | GENERAL INSURANCE

CORONA KAVACH POLICY,
EDELWEISS GENERAL INSURANCE COMPANY LIMITED
CLAIM FORM A

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
2. This form is not an admission of liability.

SECTION A – SOME DETAILS ABOUT YOU AND YOUR POLICY

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

c) Company/ TPA ID No.: | | | | | | | | | | | | | | | | | | | | | | |

d) Name: _____ e) Address: _____

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

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

SECTION B – SHARE YOUR PAST/OTHER INSURANCE INFORMATION

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 Number: _____ Sum Insured (₹): _____

d) Have you been hospitalized in the last four years since start of the contract? Yes ☐ No ☐

Date: M M Y Y Y Y Diagnosis: _____

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

f) If yes, Company Name: _____

SECTION C – A BIT ABOUT THE PERSON HOSPITALIZED

a) Name: _____ b) Gender: Male ☐ Female ☐ Third Gender ☐

d) Age: | | years | | 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) Address (if different from above): _____

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

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

SECTION D – DETAILS ABOUT THE HOSPITAL / HOME CARE EXPENSES, PLEASE

a) Name of Hospital where Admitted: _____

b) Room category occupied: Day Care ☐ Single Occupancy ☐ Twin Sharing ☐ 3 or more beds per room ☐ General Ward ☐

c) Expenses related to: Hospitalization due to Covid -19 Confirmed Case ☐ or Home care treatment expenses of Covid-19 ☐

d) Date the disease was first detected: D D M M Y Y Y Y

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

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

g) System of Medicine used for treatment: _____

SECTION E – ABOUT YOUR CLAIM

a) Details of the treatment expenses claimed

(i) Pre-hospitalization Expenses: ₹_____ (ii) Hospitalization Expenses: ₹_____

(iii) Post-hospitalization Expenses: ₹_____ (iv) Ambulance Charges: ₹_____

(v) Pre-hospitalization period: ₹_____ (vi) Post-hospitalization period: _____ days

(vii) Hospital Daily Cash in case of add on cover ₹_____ Total: ₹_____

b) The documents we'll need

- ☐ Signed Claim Form
- ☐ Copy of the claim intimation, if any
- ☐ Hospital Main bill
- ☐ Hospital Break-up bill
- ☐ Hospital Discharge summary
- ☐ Hospital Bill Payment Receipt
- ☐ Pharmacy Bill
- ☐ Operation Theatre Notes if applicable
- ☐ ECG if applicable
- ☐ Doctor's request for investigations
- ☐ Investigation Reports (Including CT/MRI / USG / HPE)
- ☐ Doctor's Prescriptions or Treatment Notes
- ☐ Others like Nursing Notes or Indoor Case Papers
- ☐ Any other document, please specify

SECTION F – DETAILS OF YOUR TREATMENT BILLS

Sr.No.	Bill No.	Date	Issued by	Towards	Amount (₹)
1		(DD/MM/YYYY)		Hospital Main bill	
2		(DD/MM/YYYY)		Pre-Hospitalization Bills: ___ Nos	
3		(DD/MM/YYYY)		Post-Hospitalization Bills: ___Nos	
4		(DD/MM/YYYY)		Pharmacy Bills	
5		(DD/MM/YYYY)			

SECTION G - THE PRIMARY INSURED'S BANK ACCOUNT DETAILS

a) PAN: ☐☐☐☐☐☐☐☐☐☐ b) Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c) Bank Name and Branch: _____

d) Cheque/DD Payable details: ☐☐☐☐☐☐☐☐ e) IFSC: ☐☐☐☐☐☐☐☐☐☐☐

GUIDANCE FOR FILLING CLAIM FORM – PART A (TO BE FILLED BY THE INSURED PERSON)

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As given by the insurance company
b) SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As given by the organization
c) Company TPA ID No.	Enter the TPA ID No.	License number as allotted by IRDAI and printed in TPA documents
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin Code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any othe Mediclaim/Health Insurance?	Tell us if the insured person is currently covered by another Mediclaim/Health Insurance	Tick Yes or No
b) Date of Start of first insurance without break	Enter the date of start of first insurance	Use dd-mm-yy format
c) Company Name	Enter the full name of the insurance company	
Policy No.	Enter the policy number	Name of the organization in full
Sum Insured	Enter the total sum insured as per the policy	As allotted by the insurance company
d) Have you been Hospitalized 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-yy 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 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 to primary Insured	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
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
i) 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 hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Expenses pertaining to	Give us details of hospitalisation/Home care expenses as applicable	Tick the right option
d) Date the Disease was first detected	Enter the relevant date	Use dd-mm-yyyy format
e) Date of admission	Enter date of admission	Use dd-mm-yyyy format
Time	Enter time of admission	Use hh:mm format
f) Date of discharge	Enter date of discharge	Use dd-mm-yyyy format
Time	Enter time of discharge	Use hh:mm format
g) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
i) Pre-hospitalisation Expenses	Enter the amount spent before hospitalisation	In rupees (Do not enter paise values)
ii) Hospitalisation Expenses	Enter the amount claimed as hospital expenses as per the final hospital bill	In rupees (Do not enter paise values)
iii) Post-Hospitalisation Expenses	Enter the amount spent after discharge from the Hospital	In rupees (Do not enter paise values)
iv) Ambulance charges	Enter the amount claimed as expenses for an Ambulance	In rupees (Do not enter paise values)
v) Pre-Hospitalization period	Indicate the no. of days for which you paid for treatment before hospitalisation	Enter no. of days
vi) Post – Hospitalization period	Indicate the no. of days for which you paid for treatment after discharge	Enter no. of days
vii) Hospital daily cash	Indicate the no. of days for which daily cash needed during hospitalisation	Enter no. of days
	is claimed	
b) Claim Documents Submitted Check List	Let us know which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLS ENCLOSED		In rupees (Do not enter paise values)
Indicate which bills are enclosed with the amounts in rupees		Tick the right option
SECTION G - DETAILS IN CASE OF NON-NETWORK HOSPITAL		
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 H – DECLARATION BY THE INSURED

Read declaration carefully and mention the date

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 TPA / 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 bills / receipts for the purpose of this claim & that I will not be making any other claim except the pre / post Hospitalization claim, if any.

Date: D D M M Y Y Y Y

Place: _____

Signature of the Member