

Need to claim? We won't play the claim game!

Arogya Sanjeevani Policy, Zuno General Insurance limited

Claim form - A

Instructions:

This form is not an admission of liability.

Section A – Details of the primary insured					
a) Policy No.: b) Sl. No ./ Certificate No: b)					
c) Company/ TPA ID No.:					
d) Name: e) Address:					
City: Pin code:					
Phone No.: Email ID:					
Section B – Details of insurance history					
a) Currently covered by any other mediclaim/ health insurance: Yes 🗌 No 🗌					
b) Date of commencement of first insurance without break: DDDMMYYYYYY					
c) If yes, company name: Policy number: Sum insured (INR):					
d) Have you been hospitalized in the last four years since inception of the contract? Yes 📃 No					
Date: D M M Y Y Y Diagnosis:					
e) 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: DDMMYYYY					
e) Relationship with primarily insured: Self Spouse Child Father Mother Other (Please Specify)					
f) Occupation: Service Self-employed Homemaker Student Other (Please Specify)					
g) Address (if different from above):City:State:					
Pin code:					
Section D – Details of hospitalization					
a) Name of hospital where admitted:					
b) Room category occupied: Day care Single occupancy Twin sharing 3 or more beds per room					
c) Hospitalization due to: Injury 🔄 Illness 🔄 Maternity 🔄					
d) Date of Injury / date disease first detected /date of delivery: DDMMYYYY					
e) Date of admission: DDMMYYYY Time: HHMM					
f) Date of discharged: DDMMYYYY Time: HHMM					
g) If injury, what caused it? Self inflicted 🗌 Road traffic accident 🗌 Substance abuse /alcohol consumption 🗌					
h) If medico legal: (i)Yes No (ii) Reported to Police: Yes No iii) MLC report & police FIR attached: Yes No					
i) System of medicine used for treatment:					

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Section E – Details of claim

a) Details of the treatment expenses claimed			
(i) Pre-hospitalization expenses:	₹ (ii) Hospitalization expenses:		₹
(iii) Post-hospitalization expenses:	₹	(iv) Health-check-up cost:	₹
(v) Ambulance charges:	₹	(vi) Others (code)::	₹
		Total:	₹
(vii) Pre-hospitalization period:days		(viii) Post-hospitalization period:	:days
b) Claim for domiciliary hospitalization: Yes	No (If Yes, pro	vide details in annexure)	
c) Details of lump sum / cash benefit claimed:			
(i) Hospital daily cash:	₹	(ii) Surgical cash: Rs.	₹
(iii) Critical illness benefit:	₹	(iv) Convalescence:	₹
(v) Pre/Post hospitalization lump sum benefit:	₹	(vi) Others:	₹
		Total:	₹
Claim documents submitted – checklist			
Duly signed claim Form		Operation theatre notes	
Copy of the claim intimation, if any		ECG	
Hospital main bill	Doctor's request for investigation		
Hospital break-up bill	Investigation reports (Including CT/MRI / USG / HPE)		
Hospital discharge summary	Doctor's prescriptions		
Hospital bill payment receipt	Others		
Pharmacy bill			

Section F – Details of bills enclosed					
SI.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)			
6		(DD/MM/YYYY)			
7		(DD/MM/YYYY)			
8		(DD/MM/YYYY)			
9		(DD/MM/YYYY)			
10		(DD/MM/YYYY)			

Section G -Details of primarily insured's bank account					
a) PAN:	b) Account No.:				
c) Bank name and branch:					
d) Cheque/DD payable details:	e) IFSC:				

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Section H - 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, suppression or concealment of 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 / insurance company, 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 for the purpose of this claim & that I will not be making any supplementary claim except the pre/post hospitalization claim, if any. a. I hereby authorize Zuno General Insurance / Zuno authorized TPA to collect the relevant medical documents for purpose of my claim from the provider where I have taken the treatment.

Date:	D	D	M	M	γ	γ	Y	Υ
Place:								

Signature of the Insured

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 compar			
b) Si. No/ certificate no.	Enter the social insurance number or the	As allotted by the organization			
	certificate number of social health				
	insurance scheme				
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 other	Indicate whether currently covered by	Tick Yes or No			
mediclaim/health insurance?	another Mediclaim / Health Insurance				
b) Date of commencement of first insurance	Enter the date of commencement of first	Use dd-mm-yy format			
without break	insurance				
c) Company name	Enter the full name of the insurance	Name of the organization in full			
	company				
Policy no.	Enter the policy number	As allotted by the insurance company			
Sum insured	Enter the total sum insured as per the	In rupees			
	policy				
d) Have you been hospitalized in the last	Indicate whether hospitalized in the last	Tick Yes or No			
four years since Inception of the contract?	four years				
Date	Enter the date of hospitalization	Use mm-yy format			
Diagnosis	Enter the diagnosis details	Open Text			
e) Previously covered by any other	Indicate whether previously covered by	Tick Yes or No			
mediclaim/health insurance?	another Mediclaim / Health Insurance				
f) Company name	Enter the full name of the insurance	Name of the organization in full			
	company				
Section c - details of insured person hospital	ized				
a) Name	Enter the full name of the patient	Surname, First name, Middle name			
b) Gender	Indicate Gender of the patient	Tick Male or Female			
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-yy format			
e) Relationship to primary insured	Indicate relationship of patient with	Tick the right option. If others, please			
	policyholder	specify.			
f) Occupation	Indicate occupation of patient	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					

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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) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
e) Date of injury/date disease first detected/	Enter the relevant date	Use dd-mm-yy format
date of delivery		
d) Date of admission	Enter date of admission	Use dd-mm-yy format
F) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) If injury, what caused it?	Indicate cause of injury	Tick the right option
If medico legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to police	Indicate whether police report was filed	Tick Yes or No
MLC report & police fir attached	Indicate whether MLC report and Police	Tick Yes or No
	FIR attached	
j) System of medicine	Enter the system of medicine followed in	Open Text
	treating the patient	
Section e - details of claim		
a) Details of treatment expenses	Enter the amount claimed as treatment	In rupees (Do not enter paise values)
	expenses	
b) Claim for domiciliary hospitalization	Indicate whether claim is for domiciliary	Tick Yes or No
	hospitalization	
C) Details of lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/	In rupees (Do not enter paise values)
• •	cash benefit	• • • • •
D) Claim documents submitted check list	Indicate which supporting documents are	Tick the right option
	submitted	
Section f - details of bills enclosed		
Indicate which bills are enclosed with the arr	ounts in rupees	
Section g - details in case of non-network ho		
A) PAN	Enter the permanent account number	As allotted by the Income Tax depart-
	'	ment
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	Name of the Bank in full
	branch	
D) Cheque/ DD payable details	Enter the name of the beneficiary the	Name of the individual/ organization
er en equer de payable actails	cheque/ DD should be made out to	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	Enter the in Se code of the bank branch	in second of the bank branch in full
Read declaration carefully and mention date	(in dd:mm:vy format) place (open text) and	sign
Read declaration carefully and mention date	(in additionally formally, place (open text) and	51511.

Zuno General Insurance Limited, (Formerly known as Edelweiss General Insurance Company Limited) Registered Office: 2nd Floor, Tower 3, Wing B, Kohinoor City Mall, Kohinoor City, Kirol Road, Kurla (West), Mumbai - 400 070, IRDAI Regn. No.: 159, CIN: U66000MH2016PLC273758, Reach us on: 1800 12000 (Toll-Free), 022 42312000 (Call charges applicable) Email: support@hizuno.com, Website: www.hizuno.com, Issuing/Corporate Office: +91 22 4272 2200, Grievance Redressal Officer: +91 22 4231 2022, Dedicated Toll-Free Number for Grievance: 1800 120 216216.

4