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

Zuno Health Top Up Insurance

Claim form - A

Instructions:
1. This form has to be filled in BLOCK letters by the Insured / Policy Holder.
2. The filling up and submission of this Form does not make us liable to accept the Claim.

Section A – Details of primary insured

a) Policy No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ b) Serial No./ certificate No: ☐☐☐☐☐☐☐☐☐☐☐

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

d) Name: ____________ e) Aadhaar: ☐☐☐☐☐☐☐☐☐☐☐☐

f) Address- City: ____________ State: ____________ Landmark: ____________

Pin code: ☐☐☐☐☐☐ Phone No.: ☐☐☐☐☐☐☐☐☐☐ Email ID: ____________

Section B – Some details of your other/past insurance

a) Are you currently covered by any other mediclaim/ health insurance: Yes ☐ No ☐

b) Date of start of the first insurance without break:

c) If yes, company name: ____________ Policy number: ☐☐☐☐☐☐☐☐☐☐ Sum insured (INR): ____________

d) Have you been hospitalized in the last four years since the beginning of the policy? Yes ☐ no ☐

Date: D D M M Y Y Y Y Diagnosis: ____________

e) Have you opted for benefits under a different insurance policy:- Yes ☐ No ☐ If yes, please specify the details.

f) Name of the insurance company: ____________ h) Policy No: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Sum insured: ☐☐☐☐☐☐☐☐☐☐ Claimed amount: ☐☐☐☐☐☐☐☐☐☐

Section C – Details of insured person hospitalized

a) Name: ____________

b) Aadhaar / identity document and No.: ☐☐☐☐☐☐☐☐☐☐☐☐ Pan card No: ☐☐☐☐☐☐☐☐☐☐

c) Gender: Male ☐ Female ☐ Third gender ☐ d) Age: ☐☐ 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: ☐☐☐☐☐☐ i) Phone No.: ☐☐☐☐☐☐☐☐☐☐ j) Email ID:

Section D – Tell us more about the hospitalization

a) Name of hospital admitted: ____________

Address: ____________

Landmark: ____________

b) Room category occupied: Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐

c) Hospitalization due to: Injury ☐ Illness ☐ Maternity ☐

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d) Date of injury / date disease first detected /date of delivery: 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 discharged: D D M M Y Y Y Y Time: H H M M

g) If injury, give cause: 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: ________________________________

Section E – Details of claim

a) Details of the treatment being claimed for

(i) Pre-hospitalization cost: ₹ __________ (ii) Hospitalization cost: ₹ __________

(iii) Post-hospitalization cost: ₹ __________ (iv) Daycare: ₹ __________

(v) Hospital cash being claimed: ₹ __________ (vi) Details of Base Policy Co-Pay Support claimed: ₹ __________

(vii) Pre-hospitalization period:_____days (viii) Details of Base Policy Higher room rent deduction: ₹ __________

(ix) Post-hospitalization period:_____days (x) Others expenses claimed as per policy cover (code): ₹ __________

b) Claim for Domiciliary Hospitalization: Yes No (If Yes, provide details in annexure) ₹ __________

c) Details of Dental Cover Claimed: ₹ __________

d) Details of AYUSH Hospitalization or AYUSH Day care ₹ __________

e) Details of expenses under New Born baby cover: ₹ __________

f) Vaccination if opted for new born cover: ₹ __________

g) Any additional / supporting documents: ₹ __________

Total: ₹ __________

The documents we'll need

- ☐ Duly signed Claim Form
- ☐ Copy of the claim intimation, if any
- ☐ Hospital Main bill
- ☐ Hospital Break-up bill
- ☐ Hospital release in short
- ☐ Pharmacy Bill
- ☐ ECG
- ☐ Doctor's request for investigation
- ☐ Investigation Reports (Including CT/MRI / USG / HPE)
- ☐ Doctor's Prescriptions
- ☐ Hospital Bill Payment Receipt
- ☐ Operation Theatre Notes

Section F – Details of bills enclosed

Sl.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)			

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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: ☐☐☐☐☐☐☐☐☐☐

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.

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 Y Y Y Y

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 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 given by irda and printed in TPA documents
d) Name	Enter the full name of the policyholder	Surname, first name, middle name
e) Aadhaar No	Enter the aadhaar number	As given by the unique identification authority of india.
f) 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?	Indicate whether currently covered by another mediclaim / health insurance	Tick yes or no
b) Date of starting of first Insurance without break	Enter the date of starting of first insurance	Use dd-mm-yy 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 given by the insurance company
Sum insured	Enter the total sum insured as per the policy	In rupees
d) Have you been hospitalized in the last four years since inception of the contract?	Tell us if hospitalized 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) Have you opted for benefits under a different insurance policy:	Tell us if earlier 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
h) Details of base policy	Enter the full details of the insurance policy	Please insert policy copy of the base policy
Section C – Details of insured person hospitalized		
a) Name	Enter the full name of the patient	Surname, first name, middle name
b) Aadhaar / identity / PAN No	Enter aadhaar / govt issued id / pan number	As given by the unique identification authority of india. (UIDAI) / it dept/ election commission etc
c) Gender	Indicate gender of the patient	Tick male or female or third gender
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter date of birth of patient	Use dd-mm-yy format
f) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please mention.

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g) Occupation	Indicate occupation of patient	Tick the right option. If others, please mention.
h) Address	Enter the full postal address	Include street, city and pin code
i) Phone No	Enter the phone number of patient	Include std code with telephone number
j) E-mail ID	Enter the e-mail id of patient	Complete e-mail address
Section D – Share some details of the 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
d) Date of Injury/date disease first detected/ Date of delivery	Enter the relevant date	Use dd-mm-yy format
e) 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, give cause	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 fir attached	Tick yes or no
j) 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 costs	In rupees (do not enter paise values)
b) Claim for domiciliary hospitalization	Indicate whether claim is for domiciliary hospitalization	tick yes or no
c) Details of dental cover claimed:	Enter the amount claimed as lump sum/ cash benefit	In rupees (do not enter paise values)
d) Details of ayush hospitalization or AYUSH daycare	Enter the amount claimed as treatment costs	In rupees (do not enter paisa values)
e) Details of expenses under new born cover	Enter the amount claimed as treatment costs	In rupees (do not enter paisa values)
f) Vaccination expenses if opted for new born cover	Enter the amount claimed as treatment costs	In rupees (do not enter paisa values)
g) Any additional / supporting documents: co-pay deductions / Higher room rent deductions	Indicate which supporting documents are submitted along with settlement letter for the claim in which co-pay or other deductions are being claimed	Please attach the relevant details and select yes
Section F – Details of bills enclosed		
Indicate which bills are enclosed with the amounts in rupees		
Section G- Details of the insured's/nominee's bank account		
a) PAN	Enter the permanent account number	As given by the income tax department
b) Account Number c) Bank Name and branch	Enter the bank account number Enter the bank name along with the branch	As given by the bank 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 person/ organization in full
e) IFSC code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
Section H– Make your declaration		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		