

## Broad Guidelines for Claim Process

1. Please ensure Claim form is completely filled, signed and **submitted in original**.
2. Please provide at least **two contactable mobile numbers and e-mail id** for further communication related to your claim.
3. Indicative list of claim documents has been provided in the Claim Form under Section E. **Please ensure all the documents are submitted in original for smooth processing of claim.**
4. **Claim processing will be delayed in absence of original documents.**
5. **Claim payments are made only through Online Bank Transfers.** Please submit the Bank Account details along with a cancelled cheque. The bank accounts details need to be mentioned in Section G of the Claim Form.

**In addition to above, if the claim amount is more than Rs 1 Lakh then following additional documents are required:**

6. Pan Card of the Employee.

Claim documents needs to be send on below address: -

Religare Health Insurance-Claims Department  
Unit No. 604 - 607, 6th Floor, Tower C, Unitech Cyber Park, Sector-39,  
Gurugram-122001 (Haryana)

Now, track your claim status with ease

**ONLINE:** Please visit below link and enter your Client ID and Policy Number

[www.religarehealthinsurance.com/claim\\_search.php](http://www.religarehealthinsurance.com/claim_search.php) **Center/Claim Search/Enter Client ID and Policy No.**

**SMS:** Simply SMS your claim reference number in the message format CLAIM <space> CLAIMNUMBER to 77158-77158

Example: To check claim status of claim reference number I1223344, simply SMS CLAIM I1223344 to 77158-77158

## Brief description of the key documents required along with the claim form

1. Indoor Case Papers - This document is prepared by hospital on daily basis which maintains daily doctor notes, nursing notes, patient progress details and having patient condition summary from the date of admission till discharge.
2. Hospital Discharge Summary - Summary of hospitalization period including - Admission date, discharge date, diagnosis, line of treatment given to patient during hospitalization and further advice on discharge.
3. Payment Receipts - Receipts of payment done to hospital authorities towards all bills, investigation reports or any other procedure done.
4. Consultation Papers - Written prescription of the Medical Practitioner with whom patient has consulted.
5. **NEFT (Net Electronic Fund Transfer) – We require original cancelled cheque of the policyholder and relevant details to be mandatorily filled under Sector-G of claim form.**

## Terms and Conditions for Payments through RTGS/NEFT

1. The details provided by the policyholder in the mandate form shall be considered as final and Religare Health Insurance Company Limited shall not be responsible for cross verifying of any of the details provided therein.
2. The policy holder agrees that transaction through RTGS/NEFT facility may attract inward RTGS/NEFT charges, which if levied by the policyholder's bank shall be borne by the policy holder only.
3. Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company.
4. I/We further undertake to refund any excess amount whether demanded by Religare Health Insurance Company Limited or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from Religare Health Insurance Company Limited of such excess credit or such information of excess credit coming to the knowledge of the policy holder through any other source.
5. The policyholder agrees that under RTGS/NEFT facility, there may be risk of non-payment in the policyholder accounts number on the day of the credit of payments due to change in the applicable regulations pertaining to RTGS/NEFT facility or due to any other reasons without any fault/inaction/failure on part of Religare Health Insurance Company Limited or any factor beyond the control of Religare Health Insurance Company Limited.

## Claim Form - 'GROUP EXPLORE'

Please Note:

- 1) Please give the required information correctly and completely to enable us to process your claims promptly.
- 2) Use additional sheets, if required.
- 3) We may call for additional documents/ information as relevant.
- 4) The claim form should be supported by all the documents as specified in the Policy.
- 5) The issue of this form shall not to be taken or deemed to be taken as an admission of liability by the Company.

### Section A - Details of the Policy

Policy No.	:	<input type="text"/>
Insured Name	:	<input type="text"/>
Certificate of Insurance No.	:	<input type="text"/>

### Section B - Details of Insured Person / Claimant (in Case of Insured's Death)

Name	:	<input type="text"/>	(Surname)	<input type="text"/>	(First Name)	<input type="text"/>	(Middle Name)	<input type="text"/>	
Address	:	<input type="text"/>							
City	:	<input type="text"/>	State :	<input type="text"/>					
Country	:	<input type="text"/>	Pin Code :	<input type="text"/>					
Landline	:	<input type="text"/>	-	<input type="text"/>	Mobile :	<input type="text"/>			
E-mail	:	<input type="text"/>							

### Section C - Details of Claim

If a claim is made for any of the following Benefits kindly tick the appropriate Benefit and fill in the corresponding below details:-

#### Medical Cover

In-Patient care for Injury (accident) <input type="checkbox"/>	In-Patient Care <input type="checkbox"/>	Day care Treatment <input type="checkbox"/>
<u>Optional Extensions to Medical Cover :-</u>		
Pre-Existing Disease Cover In Life Threatening Medical Condition <input type="checkbox"/>	Maternity <input type="checkbox"/>	
Extended Cover in the Country of Residence / City of Residence <input type="checkbox"/>	HIV/AIDS Cover <input type="checkbox"/>	
Treatment of Mental & Nervous Disorder <input type="checkbox"/>	Drug and Alcohol Abuse <input type="checkbox"/>	
Self-Inflicted Injury <input type="checkbox"/>	Maternity Complications <input type="checkbox"/>	Adventure Sports Injury <input type="checkbox"/>
Corporate Floater <input type="checkbox"/>	Recharge of Sum Insured <input type="checkbox"/>	

#### Out-patient Cover

Out-Patient care for Injury(accident) <input type="checkbox"/>	Out-Patient Care <input type="checkbox"/>	
<u>Optional Extensions to Out-patient Cover :-</u>		
Pre-Existing Disease Cover In Life Threatening Medical Condition <input type="checkbox"/>	Treatment of Mental & Nervous Disorder <input type="checkbox"/>	
Radiotherapy and Chemotherapy Charges <input type="checkbox"/>	Vaccination Charges <input type="checkbox"/>	
Cancer screening & Mammography <input type="checkbox"/>	Adventure Sports Injury <input type="checkbox"/>	Non-emergency OPD consultation <input type="checkbox"/>

#### Medical Evacuation

Daily Allowance

Health Check-up

#### Dental expenses

Home Care

#### Maternity Cash Benefit

Non-Allopathic Treatments

Name, address and telephone number of Hospital where treatment was given: \_\_\_\_\_

Name of treating doctor/dental surgeon: \_\_\_\_\_

Details of Illness/Injury: \_\_\_\_\_

Cause of the Illness/Injury: \_\_\_\_\_

Was the Illness/incident caused/ aggravated due to a pre-existing condition? Please give details: \_\_\_\_\_

Date of onset of Illness (DDMMYYYY) :

Nature of treatment: \_\_\_\_\_

Date of treatment (DDMMYYYY) : From  To

Reason for Medical Evacuation (If Medical Evacuation) \_\_\_\_\_

Medical Evacuation From: \_\_\_\_\_ To \_\_\_\_\_ Date:

Serial No.	Expense Details	Amount(Rs)

### Repatriation of Mortal Remains

Cause of death: \_\_\_\_\_

Date of death of Insured (DDMMYYYY):  Total expenses \_\_\_\_\_

Transportation From: \_\_\_\_\_ To \_\_\_\_\_ Date:

### Loss of Checked-in Baggage

### Delay of Checked-in Baggage

Name of Common Carrier: \_\_\_\_\_

In case of loss of checked-in Baggage

Date of loss (DDMMYYYY) :  Place of loss: \_\_\_\_\_

In case of delay of checked-in Baggage

Date and time of arrival date :  Time (HHMM):

Port of disembarkation: \_\_\_\_\_

Date and time of baggage retrieval: Date  Time (HHMM):

Serial No.	Expense Details	Amount(Rs)

### Loss of Passport

### Emergency Cash Advance

### Personal Liability

### Identity Document Theft

Date of loss (DDMMYYYY) :  Place of loss: \_\_\_\_\_

Detail of loss: \_\_\_\_\_

Name of aggrieved third party (in case of Personal Liability): \_\_\_\_\_ Total expenses \_\_\_\_\_

#### Religare Health Insurance Company Limited

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Website: www.religarehealthinsurance.com E-mail: customerfirst@religarehealthinsurance.com Call us: 1800-102-4488 | 1860-500-4488

CIN: U66000DL2007PLC161503 UIN: IRDAI/HLT/RHI/P-T/V.I/53/14-15 IRDA Registration No. - 148

**Personal Accident**

**Common Carrier Fatality**

Cause of Accident: \_\_\_\_\_

Nature of loss/ Injury: \_\_\_\_\_

Place of Accident: \_\_\_\_\_ Details of Common Carrier: \_\_\_\_\_

Name, address and telephone number of hospital/clinic where treatment was given: \_\_\_\_\_

Name of treating doctor: \_\_\_\_\_

Date of medical/surgical treatment (DDMMYYYY): From  To

Date of death (DDMMYYYY) :

**Hijack Distress Allowance**

Name of Common Carrier: \_\_\_\_\_

Port of Hijack: \_\_\_\_\_ Port of release: \_\_\_\_\_

Date of Hijack (DDMMYYYY) : From  To

Time of Hijack (HHMM) : From  To

**Trip Cancellation**

**Trip Interruption**

**Trip Delay**

**Missed Connection**

**Hotel Cancellation**

**Bounce Booking**

Name of Common Carrier /Hotel : \_\_\_\_\_

Scheduled departure: Date (DDMMYYYY)  Time (HHMM)

Scheduled arrival: Date (DDMMYYYY)  Time (HHMM)

Common Carrier route : From: \_\_\_\_\_ To: \_\_\_\_\_

Name of Common Carrier /Hotel : \_\_\_\_\_

Actual departure: Date (DDMMYYYY)  Time (HHMM)

Actual arrival: Date (DDMMYYYY)  Time (HHMM)

Common Carrier route : From: \_\_\_\_\_ To: \_\_\_\_\_

For Missed Connection only :-

Name of Connecting Common Carrier : \_\_\_\_\_

Connecting Common Carrier route : From: \_\_\_\_\_ To: \_\_\_\_\_

Scheduled departure: Date (DDMMYYYY)  Time (HHMM)

Description of incident : \_\_\_\_\_

Total expenses \_\_\_\_\_

**Up-gradation to Business Class**

Name, address and telephone number of hospital/clinic where treatment was given: \_\_\_\_\_

Name of treating doctor: \_\_\_\_\_

Details of the Injury: \_\_\_\_\_

Date of Hospitalization (DDMMYYYY): From:  To:

Details of journey : From: \_\_\_\_\_ To: \_\_\_\_\_

Date :  Total expenses \_\_\_\_\_

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**Compassionate Visit**  **Return of Minor Child**  **Replacement of Staff**  **Parent Accommodation**

Name, address and telephone number of hospital/clinic where treatment was given: \_\_\_\_\_

Name of treating doctor: \_\_\_\_\_

Details of illness: \_\_\_\_\_

Cause of the illness: \_\_\_\_\_

Nature of treatment: \_\_\_\_\_

Date of Hospitalization (DDMMYYYY) :

Treating doctor's opinion on how many more days the patient will need to be hospitalized:

Treating doctor's opinion on why the patient cannot be sent back to Country of Residence for further treatment: \_\_\_\_\_

Treating doctor's opinion on need for an attendant: \_\_\_\_\_

Details of journey: From \_\_\_\_\_ To: \_\_\_\_\_

Total expenses \_\_\_\_\_

### Emergency Hotel Accommodation / Extension

Name of hotel: \_\_\_\_\_

Booking date (DDMMYYYY) :  Confirmation date:

Reason for emergency hotel accommodation / extension: \_\_\_\_\_

Total expenses \_\_\_\_\_

### Spectacles Damage

Loss date :

Cause of damage: \_\_\_\_\_

Description of item damaged: \_\_\_\_\_ Total expenses \_\_\_\_\_

### Re-imbusement of Golf Fees

Loss date :

Reason for loss: \_\_\_\_\_

Details of expenses incurred: \_\_\_\_\_

Total expenses \_\_\_\_\_

### Political Risk and Catastrophe Evacuation

Date of evacuation :

Reason for Evacuation: \_\_\_\_\_

Total expenses \_\_\_\_\_

### Loss of Laptop / Tablet / Hand baggage

Loss date :

Reason for loss: \_\_\_\_\_

Details of expenses incurred: \_\_\_\_\_

Total expenses \_\_\_\_\_

**Bail Bond**

Name and contact details of the detaining authority: \_\_\_\_\_

The offence for which Insured is in custody: \_\_\_\_\_

Is this offence bailable as per the laws of the detaining country?: Yes  No 

Total expenses \_\_\_\_\_

**Sponsor Protection**

Name of the sponsor: \_\_\_\_\_

Cause of accident causing demise of the sponsor: \_\_\_\_\_

Nature of Injury causing the demise of the sponsor: \_\_\_\_\_

Place of accident of the sponsor: \_\_\_\_\_

Name, address and telephone number of hospital/clinic where treatment was given to the sponsor: \_\_\_\_\_

Name of treating doctor of the sponsor: \_\_\_\_\_

Details of medical/surgical treatment given to sponsor: \_\_\_\_\_

Date of medical/surgical treatment (DDMMYYYY) : From  To Date of Accidental Death (DDMMYYYY) : **Study Interruption***Due to Hospitalization of the Insured* 

Name, address and telephone number of hospital/clinic where treatment is being given: \_\_\_\_\_

Name of treating doctor: \_\_\_\_\_

Details of Illness: \_\_\_\_\_

Cause of the Illness: \_\_\_\_\_

Nature of treatment: \_\_\_\_\_

Dates of Hospitalization (DDMMYYYY) : From  To 

Reason for medical evacuation (if applicable): \_\_\_\_\_

Reason for not continuing studies abroad: \_\_\_\_\_

Tuition Fees paid in advance for the year : *Due to death of immediate family member* 

Name of the immediate family member: \_\_\_\_\_

Cause of accident causing demise of the immediate family member: \_\_\_\_\_

Nature of Injury causing the demise of the immediate family member: \_\_\_\_\_

Place of accident of the immediate family member: \_\_\_\_\_

Name, address and telephone number of hospital/clinic where treatment was given to the immediate family member: \_\_\_\_\_

Name of treating doctor of the immediate family member: \_\_\_\_\_

Details of medical/surgical treatment given to immediate family member: \_\_\_\_\_

Dates of medical/surgical treatment (DDMMYYYY): From  To 

Reason for not continuing studies abroad: \_\_\_\_\_

Tuition Fees paid in advance for the year : **Religare Health Insurance Company Limited**

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Name of the University: \_\_\_\_\_

FIR / Complaint date and Number: \_\_\_\_\_

Details of expenses incurred: \_\_\_\_\_

I/We hereby agree, affirm and declare that:

- a. The information/statements given/ stated by me/us in this claim form are true, correct and complete.
- b. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.
- c. If I/we have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the Policy shall be void and that I/We shall not be entitled to all/any rights to recover there under in respect of any or all claims, past, present or future. The receipt of this claim form/other supporting/related documents does not constitute or deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further information and documents in respect of the claim.
- d. I hereby authorize the physician or hospital or police authorities or governmental agency or any other institute to provide to Religare Health Insurance Company Limited, or its offices or legal advisers or any investigative agency or their representative acting on its behalf, information regarding the deceased's state of health, employment, finances or insurance, advice, treatment provided to the deceased or any information that may be required concerning the health of the deceased including information relating to mental illness, use of drugs, use of alcohol. A copy of this authorization shall be considered as effective and valid as the original.
- e. I do hereby authorize Subrogation Agency to inquire and obtain any information regarding my accident. Further, the Company is hereby authorized to release any and all information, including copies of pertinent documents, which Subrogation Agency may deem necessary in order to satisfy their inquiry. If during the investigation, Subrogation Agency has identified a potential recovery source, allowing the Plan Participant's employer to recover paid benefits, Subrogation Agency is authorized to release any all records they deem necessary in order to pursue the recovery

Date :  /  /  (DD/MM/YYYY)

Signature of the Claimant : \_\_\_\_\_

Place : \_\_\_\_\_