

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

Zuno Health 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 the primary insured / policyholder
a) Policy No.: b) Sl. No ./ Certificate No:
c) Company/ TPA ID No.:
d) Name: e) Address:
City: State: 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: DDMMYYYYY Diagnosis:
e) Were you previously covered by any other mediclaim / health insurance? Yes No
f) If yes, company name:
Section C – Details of hospitalized insured person / policy holder
a) Name:
b) Gender: Male Female Third gender c) Age: Years Months d) Date of birth: DDMMYYYYY
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: i) Email ID:
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:
e) Date of admission: DDMMYYYYYY Time: HHMM
f) Date of discharged: DDMMYYYYY Time: HHMM
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	n E – details	s of claim			
a) Deta	ails of the t	reatment expenses cla	imed		
(i) Pre-	hospitaliza	tion expenses:	₹	(ii) Hospitalization expenses:	₹
(iii) Post-hospitalization expenses: ₹		₹	(iv) Health-check-up cost:	₹	
(v) Ambulance charges: ₹		₹	(vi) Others (code)::	₹	
				Total:	₹
(vii) Pre	e-hospitaliz	ation period:day	'S	(viii) Post-hospitalization period:	days
b) Clair	m for domi	ciliary hospitalization:	Yes No (If Yes, provi	de details in annexure)	
c) Deta	ils of lump	sum / cash benefit cla	imed:		
				(ii) Surgical cash: Rs.	₹
(iii) Cri	tical illness	benefit:	₹	(iv) Convalescence:	₹
(v) Pre/	/Post hospi	talization lump sum be	enefit: ₹	(vi) Others:	₹
		submitted – checklist		Total:	₹
Saction	Hospital Hospital Pharmac	break-up bill discharge summary bill payment receipt		Doctor's request for investigation Investigation reports (Including (Doctor's prescriptions Others	
Sl.No.	Bill No.	Date	Issued by	Towards	Amount (₹)
1	DIII IVO.		issued by		Amount (1)
2		(DD/MM/YYYY)		Hospital main bill	
		(DD/MM/YYYY) (DD/MM/YYYY)		Hospital main bill Pre-hospitalization bills: Nos	
3					
		(DD/MM/YYYY)		Pre-hospitalization bills: Nos	
3		(DD/MM/YYYY) (DD/MM/YYYY)		Pre-hospitalization bills: Nos Post-hospitalization Bills:Nos	
3		(DD/MM/YYYY) (DD/MM/YYYY) (DD/MM/YYYY)		Pre-hospitalization bills: Nos Post-hospitalization Bills:Nos	
3 4 5		(DD/MM/YYYY) (DD/MM/YYYY) (DD/MM/YYYY) (DD/MM/YYYY)		Pre-hospitalization bills: Nos Post-hospitalization Bills:Nos	
3 4 5 6		(DD/MM/YYYY) (DD/MM/YYYY) (DD/MM/YYYY) (DD/MM/YYYY) (DD/MM/YYYY)		Pre-hospitalization bills: Nos Post-hospitalization Bills:Nos	
3 4 5 6 7		(DD/MM/YYYY) (DD/MM/YYYY) (DD/MM/YYYY) (DD/MM/YYYY) (DD/MM/YYYY) (DD/MM/YYYY)		Pre-hospitalization bills: Nos Post-hospitalization Bills:Nos	
3 4 5 6 7 8		(DD/MM/YYYY) (DD/MM/YYYY) (DD/MM/YYYY) (DD/MM/YYYY) (DD/MM/YYYY) (DD/MM/YYYY) (DD/MM/YYYY)		Pre-hospitalization bills: Nos Post-hospitalization Bills:Nos	
3 4 5 6 7 8 9 10 Section a) PAN: c) Bank	:	(DD/MM/YYYY)	b) <i>i</i>	Pre-hospitalization bills: Nos Post-hospitalization Bills:Nos	



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.

Date: DDMMYYYY 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 compa	
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			



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/		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, 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 expenses	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 lump sum/ cash benefit claimed		In rupees (Do not enter paise values)
D) Claim documents submitted check list	Indicate which supporting documents are submitted	Tick the right option
Section f - details of bills enclosed		
Indicate which bills are enclosed with the am	ounts in rupees	
Section g - details in case of non-network ho	spital	
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 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		

