ZURICH kotak
General Insurance

Submit your duly filled claim form and documents to:
Paramount Health Services & Insurance TPA Pvt. Ltd., Plot No.A-442,Road No-28,Wagle Estate,Ram Nagar,Thane West - 400604

ZK - 25-26/v1

Group Smart Cash - Claim Form

(The issue of this Form is not to be taken as an admission of liability)

SECTION I- TO BE COMPLETED BY INSURED PERSON/ CLAIMANT

A. Details of Policy Holder:

I. Name of Corporate/ Group Administrator : ii.Policy Number:

iii. Name of Policy Holder:

iv. Address:

v. Date of Birth: D D M M Y Y Y Y vi. Occupation/Designation:

vii. Telephone Number: viii. Mobile No:

ix. Email:

B. Details of the Insured in respect of whom claim is made

I. Name of Insured Person:

ii. Address:

iii. Date of Birth: D D M M Y Y Y Y iv. Occupation/ Designation :

v. Telephone Number: vi. Mobile No:

vii. Email:

viii. Relationship with Policy Holder:

ix. Date (DD/MM/YYYY) and Time of injury sustained or disease/illness first detected:

x. Nature of illness/disease contracted or injury suffered :

xi. Name and address of attending Medical Practitioner:

xii. Name & address of hospital/ Nursing Home where treatment is being taken:

xii. Type of Room on admission ICU Non- ICU

xiv. Date of Admission: D D M M Y Y Y Y Time of Admission:

xv. Date of Discharge: D D M M Y Y Y Y Time of Discharge:

xvi. No of Days in ICU xvi. No of Days in Non- ICU/ Room/Ward

C. In Case of Accidental Claims:

I. Details of Hospitalization immediately after the accident

i. Place of Accident/Injury/Death:

ii. Details of Accident and Nature of Accident:

iii. Did the Accident happen when you were working: Yes No

iv. Whether reported to Police: Yes No

If Yes, Name and Address of Police Station:

If No, Give reasons:

v. First Information Report (FIR)/ Medico Legal Certificate (MLC)/ Missing complaint Number and Date:

vi. Contact Details of Police Station:

vii. Were you hospitalized immediately after the accident: Yes No (If Yes, give the following)

viii. Name and Address of the Hospital:

ix. Date of Admission: D D M M Y Y Y Y Time of Admission:

x. Date of Discharge: D D M M Y Y Y Y Time of Discharge:

II. Details of Witnesses

I. Was there any witness to the event: ☐ Yes ☐ No (If Yes, complete the following):

ii. Name:

iii. Address:

iv.Pin code:

v. Place of Witness: vi. Phone Number(Work): vii. Phone Number(Mobile):

Please attach all original witness statements if already obtained.

D. Details of Benefits Claimed:

Sr. No.	Benefits under the Policy	Sum Insured/ Daily Cash Amount	No. of Days
	Base Covers		
1.	Hospital Daily Cash Benefit	₹ per day	days
2.	Accident Daily Cash Benefit	₹ per day	days
3.	ICU Daily Cash Benefit	₹ per day	days
	Optional Covers		
1.	Convalescence Benefit	₹ per day	days
2.	Companion Benefit	₹ per day	days
3.	Joint Hospitalisation	₹	NA
4.	Parent Accommodation	₹ per day	days
5.	Day Care Procedure Benefit	₹	NA
6.	Surgery Benefit	₹	NA
7.	Accidental Hospitalisation Benefit	₹	NA
8.	Broken Bones	₹	NA
9.	Burns	₹	NA
10.	Maternity Benefit	₹ per day	days
11.	New Born Baby Benefit	₹ per day	days
12.	Worldwide Cover	₹ per day	days
13.	Personal Accident Benefit	₹	NA
14.	Critical Illness Benefit	₹	NA

E. Check List of Enclosures for Submission of Claim

I. Basic documents required for all Claims:

(i) Applicable KYC documents along with latest photographs, Valid Photo ID, address proof, etc.

(ii) Duly completed and signed Claim form in original as prescribed by Us.

II. Additional documents for Benefits (as applicable under each Section):

Sr. No.	Name of the Cover	Documents
1.	Hospital Daily Cash Benefit	Hospital discharge card/ summary, copy of treatment papers, medical investigation reports and copy of hospital bill
2.	Accident Daily Cash Benefit	Hospital discharge card/ summary, copy of treatment papers, medical investigation reports and copy of hospital bill
3.	ICU Daily Cash Benefit	Hospital discharge card/ summary, copy of treatment papers, medical investigation reports and copy of hospital bill
4.	Convalescence Benefit	Hospital discharge card/ summary
5.	Companion Benefit	Hospital discharge card/ summary and document to confirm relationship with the Patient
6.	Joint Hospitalisation	Hospital discharge card/ summary of each Insured Person hospitalised
7.	Parent Accommodation	Copy of discharge card and document to confirm relationship with the Patient
8.	Day Care Procedure Benefit	Hospital discharge card/ summary, copy of treatment papers, medical investigation reports and copy of hospital bill
9.	Surgery Benefit	Hospital discharge card/ summary, copy of treatment papers, medical investigation reports and copy of hospital bill
10.	Accidental Hospitalisation Benefit	Medical investigation report, Original hospital bill & receipts and Treatment papers,, FIR (if done) or MLC (if conducted) for Accident cases
11.	Broken Bones	a. X-Ray/ MRI/ CT-Scan/ Radiology Films/ Reports confirming the extent of fracture, Copy of treatment papers
12.	Burns	Certificate from the treating doctor certifying the extent of burns injury, Copy of treatment papers

III. In case of Accidental Death:

(i) Original Death certificate issued by the office of Registrar of Birth & Deaths;
(ii) Death summary issued by a Hospital;
(iii) Post Mortem Report (if conducted);
(iv) Copies of Medical records (if available), investigation reports (if available), if admitted to hospital
(v) Identity proof of Nominee or Original Succession Certificate/Original Legal Heir Certificate or any other proof to the satisfaction of the Company for the purpose of a valid discharge in case nomination is not filed by deceased.

IV. Documents required in case of Permanent Total Disablement

(i) Original treating Medical Practitioner's certificate describing the disablement;
(ii) Original Discharge summary from the Hospital;
(iii) Photograph of the Insured Person reflecting the disablement;
(iv) Prescriptions and consultation papers of the treatment; Disability certificate issued by civil surgeon or equivalent appointed by the District/State or Government Board.
(v) Copies of Medical records (if available), investigation reports (if available), if admitted to hospital.
(vi) Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable

V. Documents required in case of Critical Illness Claims

(i) Duly completed claim form;
(ii) Certificate from the attending Medical Practitioner of the Insured Person confirming, inter alia,
(iii) Name of the Insured Person;
(iv) Name, date of occurrence and medical details confirming the event giving rise to the Claim.
(v) Written confirmation from the treating Medical Practitioner that the event giving rise to the Claim does not relate to any Pre-Existing Disease or any illness or Injury which was diagnosed within the first 90 days of commencement of first Policy Period with Us.
(vi) Original Policy document;
(vii) Original Discharge Certificate/Death Summary/Card from the hospital/ Medical Practitioner;
(viii Original investigation test reports, indoor case papers;
(ix) In the cases where Critical Illness arises due to an Accident, FIR copy or medico legal certificate (if done/conducted) will also be required wherever conducted. We may call for any additional necessary documents/information as required based on the circumstances of the claim.
(x) Any other documents as may be required by Us.

F. Details of Policy Holder's Bank Account:

Please furnish the details below along with copy of cancelled cheque.

Account No.

IFSC/MICR Code

Bank Name

Account Holder Name

G. Declaration by the Insured:

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 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.

Date: D D M M Y Y Y Y Place: Signature:

SECTION II: TO BE FILLED BY NOMINEE (IN THE EVENT OF POLICY HOLDER'S DEATH)

Name of Nominee:

Address:

Date of Birth: D D M M Y Y Y Y Relationship with the Deceased:

Telephone Number: Mobile Number:

Email:

DECLARATION BY NOMINEE (IN THE EVENT OF POLICY HOLDER'S DEATH):

I/We hereby declare that the foregoing particulars are true & correct to the best of my knowledge and belief. I also authorize Insurance Company to make payment of the claim admissible as per terms, conditions and limitations to the Insured person or his legal heir as full and final settlement. I/We will keep indemnified and hold Zurich Kotak General Insurance Company (India) Limited harmless from any claim under this policy by any third party.

Date: D D M M Y Y Y Y Place: Signature:

SECTION III: TO BE FILLED BY TREATING DOCTOR WHO ATTENDED THE INSURED

Name of the Insured ('Patient'):

Date of Birth: D D M M Y Y Y Y Age:

1. Are you the patient's usual medical attendant? ☐ Yes ☐ No

   i. If Yes, since when? D D M M Y Y Y Y

   ii. If you have treated him/her for any previous illness or injury, please give details:

2. Details of the consultation by the Patient for present injury.

   i. Date of first consultation: D D M M Y Y Y Y

   ii. Presenting Complaints:

   iii. Nature of Injury:

   iv. History reported:

   v. Extent of Injury:

   vi. Diagnosis:

   vii. Treatment given:

   viii. If hospitalized:

   Date of Admission: D D M M Y Y Y Y Time of Admission:

   Date of Discharge: D D M M Y Y Y Y Time of Discharge:

3. Has the patient sustained a similar injury previously or aggravated a pre-existing condition? ☐ Yes ☐ No

   If Yes, please give details:

4. Cause of Present Injury ☐ Self-Inflicted ☐ Road Traffic Accident ☐ Substance Abuse/ Alcohol abuse ☐ Other:

   Please provide details of cause of injury:

5. Is the cause traceable to any disease, previous injuries: ☐ Yes ☐ No

   If Yes, please give details:

6. Are Injuries sustained in this accident the sole cause of disablement: ☐ Yes ☐ No

7. Please specify the number of days when the injured person is advised rest/unfit and should be confined to bed/house as the direct and sole consequence of the injury sustained

   From: D D M M Y Y Y Y To: D D M M Y Y Y Y

   i. Will the Injured person be able to attend to his/her normal duties? ☐ Yes ☐ No

   ii. If Yes, from what date: D D M M Y Y Y Y

8. Has the accident resulted into loss of hands/ feet/ eye/s or permanent disability of any other type which may prevent Insured from engaging in or being occupied with or giving attention to any employment or occupation whatsoever? ☐ Yes ☐ No

   If Yes, please give details:

9. Is the injured person suffering from any disease or illness apart from his injury which may tend to retard recovery? ☐ Yes ☐ No

   If Yes: Give particulars:

10. Was he/she under the influence of alcohol/intoxicants or drugs at the time of accident? ☐ Yes ☐ No

11. Nature of disablement:

    i. Permanent Total Disablement ☐ Yes ☐ No

    ii. Permanent Partial Disablement ☐ Yes ☐ No

    iii. Please specify percentage: %

12. Was the history provided by the Insured ('Patient')/ others? If 'others' please furnish details below:

    i. Name and relation with the Insured:

13. Has the patient been referred to any other Doctor for current / associated ailment? If so, please furnish details below:

    1. Name and address of the doctor / hospital:

I hereby state that I have treated the Patient in connection with the above condition and that the facts as given above are correct to the best of my knowledge.

Name of the Doctor | Registration Number

Qualification | Specialization

Address

Contact Number

Signature:

Date: D D M M Y Y Y Y Place:

SECTION IV: TO BE FILLED BY EMPLOYER

1. Name of the Company:
2. Address & Contact Details of the Company:
3. Name of the Employee:
4. Date of Joining Service: 5. Designation:
6. Please provide details of the leave availed by the employee, specifying the type of leave.

Sr. No.	Date from which leave is taken	Date when resumed duties	No. of Days	Type of Leave	In case of Sickness Leave, medical certificate produced- Yes/ No	Reason for Leave

Signature and Seal of the authorized signatory of the Company:

Name of the Authorised Signatory: Designation:

Date: D D M M Y Y Y Y Place:

GUIDANCE FOR FILLING CLAIM FORM –(To be filled in by the Insured/ claimant)

Data element	Description	Format
SECTION I- TO BE COMPLETED BY INSURED PERSON		
A. Details of Policy Holder:		
i. Name of Corporate	Enter the company name	Free Text
ii. Policy Number	Enter the policy number	As allotted by the insurance company
iii. Name of Policy Holder	Enter the Full Name of the Policy Holder	First Name, Middle Name, Surname
iv. Address	Enter the Full Postal Address	Include Street, City, State and Pin Code
v. Date of Birth (DD/MM/YYYY)	Enter Date of Birth of Policyholder	Use DD/MM/YYYY format
vi. Occupation/ Designation	Indicate Occupation/Designation of Policy Holder	Please specify the Occupation/Designation

vii. Telephone Number	Enter the Phone Number of Policyholder	Include STD code with telephone number
viii. Mobile No	Enter the Mobile Number of Policyholder	Please enter a 10 digit number
ix. Email	Enter E-mail Address of Policyholder	Complete E-mail Address
B. Details of the Insured in respect of whom claim is made		
i. Name of Insured Person	Enter the Full Name of the Insured	First Name, Middle Name, Surname
ii. Address	Enter the Full Postal Address	Include Street, City, State and Pin Code
iii. Date of Birth (DD/MM/YYYY)	Enter Date of Birth of Insured	Use DD/MM/YYYY format
iv. Occupation/Designation	Indicate Occupation/Designation of Insured	Please specify the Occupation/Designation.
v. Telephone Number	Enter the Phone Number of Insured	Include STD code with telephone number
vi. Mobile No	Enter the Mobile Number of Insured	Please enter a 10 digit number
vii. Email	Enter E-mail Address of Insured	Complete E-mail Address
viii. Relationship with Policy Holder	Indicate Relationship of Insured with Policyholder	Please specify the relationship
ix. Date (DD/MM/YYYY) and Time of injury	Enter the Date and Time of Time of injury sustained	Use DD/MM/YYYY format
sustained or disease/illness first detected	or disease/illness as the case may be	Use HH:MM format
x. Nature of illness/disease contracted or	Indicate Nature of illness/disease contracted or	Free Text
injury suffered	injury suffered	
xi. Name and address of attending	Provide Name and address of attending	Free Text
Medical Practitioner	Medical Practitioner	
xii. Name & address of hospital/ Nursing Home	Indicate Name & address of hospital/ Nursing Home	Indicate the Full Name of Hospital Include Street,
where treatment is being taken	where treatment is being taken	City, State and Pin Code
xiii. Type of Room on admission	Indicate ICU/ Non ICU	Include Street, City, State and Pin Code
xiv. Date of Admission	Enter Date of Admission	Use DD/MM/YYYY format
Time of Admission	Enter Time of Admission	Use HH:MM format
xv. Date of Discharge	Enter Date of Discharge	Use DD/MM/YYYY format
Time of Discharge	Enter Time of Discharge	Use HH:MM format
xvi. No of Days in ICU	Mention no. of days in ICU	Enter Number
xvii. No. of Days in Non- ICU/ Room/ Ward	Mention no. of days in Non- ICU/ Room/ Ward	Enter Number
C. In Case of Accidental Claims		
i.. Place of Accident/Injury/Death	Indicate Place	Free Text
ii. Details of Accident and Nature of Accident	Indicate Details of Accident	Free Text
iii. Did the Accident happen when you were	Indicate Yes or No	Yes/ No
working		
iv. Whether reported to Police	Indicate Yes or No	Yes/ No
v. FIR Report	Indicate the Place of Witness	Enter the Place of Witness
vi. Contact Details of police Station	Enter the Phone Number of Insured	Include STD code with telephone number
Vii. Were you hospitalized immediately	Indicate if you were hospitalized after accident	Select Yes or No
after the accident		
viii. Name and Address of the Hospital	Indicate the Full Name and Postal Address	Indicate the Full Name of Hospital, Include Street,
		City, State and Pin Code
ix. Date of Admission	Enter Date of Admission	Use DD/MM/YYYY format
Time of Admission	Enter Time of Admission	Use HH:MM format
x. Date of Discharge	Enter Date of Discharge	Use DD/MM/YYYY format
Time of Discharge	Enter Time of Discharge	Use HH:MM format
D. Details of Witnesses		
i. Was there any witness to the event	Indicate whether there was any witness to the event	Select Yes or No
ii. Name	Enter the Full Name of Witness	First Name, Middle Name, Last Name
iii. Address	Enter the Full Postal Address	Include Street, City, State and Pin Code
iv. Pin code	Enter the Pin Code	Indicate the Pin Code
v. Place of Witness	Indicate the Place of Witness	Enter the Place of Witness
vi. Phone Number(Work)	Enter the Phone Number of Insured	Include STD code with telephone number
vii. Phone Number(Mobile)	Enter the Mobile Number of Insured	Please enter a 10 digit number
E. Details of Benefits Claimed		
Please Indicate the Sum Insured amount and Tick the Benefits claimed		
F. Check List of Enclosures for Submission of Claim		
Indicate documents are enclosed		
G. Details of Policy Holder's Bank Account		
Bank Name	Enter the Bank Name	Name of the Bank in full
Bank Branch	Enter Name of the Branch	Name of the Branch
Bank Account Number	Enter the Bank Account Number	As allotted by the Bank
IFSC Code	Enter the IFSC Code of the Bank Branch	IFSC Code of the Bank Branch in full
MICR Code	Enter the MICR Code	MICR Code of the Bank Branch in full
H. Declaration by the Insured		
Read Declaration carefully and mention date (in DD/MM/YYYY format), place (open text) and sign.		
SECTION II – TO BE FILLED BY NOMINEE (IN THE EVENT OF POLICY HOLDER'S DEATH)		
SECTION III – TO BE FILLED BY TREATING DOCTOR WHO ATTENDED THE INSURED		
SECTION IV - TO BE FILLED BY EMPLOYER OF THE INSURED		