CLAIM INTIMATION FORM

Apollo Munich Health Insurance Co. Ltd.
10th Floor, Tower-B, Building No. 10,
DLF Cyber City, DLF City Phase -II, Gurgaon, Haryana-122002

TOLL FREE 1800-102-0333 • www.apollomunichinsurance.com • E-mail : customerservice@apollomunichinsurance.com

1.	Apollo Munich Health Member ID Number:	
2.	Policy Number :	
3.	Name of proposer : (in whose name policy is issued)	First Name :
		Last Name :
4.	Name of person admitted:	First Name :
		Last Name :
5.	Date of Birth / Age:	(DD__ __ /MM __ __/YYYY __ __ __ __) ________________Years
6.	Address :	City: State: Pin:
7.	Date of loss/Treatment/Event :	
8.	Unique ID of Provider, If any :	
9.	Provider Name :	
10.	Provider address in case of non-network:	
11.	Provisional Diagnosis :	
12.	Treatment Planned :	
13.	Estimated Expenses :	Rs.
14.	Estimated length of stay (for inpatient treatment)	_ __ __ Days
15.	Contact details, if changed :	
16.	Intimating Persons :	
17.	Admitting Doctor details :	

AMHI/PR/H/0021/0006/102010/P

Date:

Place:

Signature of person suffering injury or legally authorized representative