ANNEX - A

HDFC ERGO General Insurance Company Limited

Claims Process-RuPay Card for Personal Accident Benefit Policy No - 2999200723397400000

Claim intimation

All the claims will intimate to the dedicated claims id npcirupay@hdfcergo.com and HDFC ERGO will register the claim and provide the claim number to the Member Bank within 2 working days with policy number in subject line.

Documents receipt / Follow-up

All documents are to be received at HDFC ERGO office at the below mentioned address as per zones:

Zone West:

Card claims
Claims
Manager
HDFC ERGO General Insurance Company Limited 6th Floor, Leela Business Park
Andheri-Kurla Road, Andheri (E), Mumbai- 400 079 Phone no: 022 -66383600

Zone North

Card Claims,
Claims
Manager,
HDFC ERGO General Insurance Company Limited 5th floor, Tower 1, Stellar IT Park,
C-25, Sector-62, Noida-
201301 Phone no: 120-
6691600

Zone East

Card Claims,
Claims

Manager,
HDFC ERGO General Insurance Company Limited Metro Towers, 10th Floor,
1 Ho Chi Minh Sarani, Kolkata:
700071 Phone no: 033-39883600

Zone South
Card Claims,
Claims
Manager,
HDFC ERGO General Insurance Company Limited 6th floor, MBC Tower, Old No.90,
New No.199, Luz Church Road, Mylapore, Chennai - 600 004 Phone no : 044-39883600

- Claim intimation should be within Thirty (30) days from the date of Loss. In case where a person is hospitalized (and under a critical condition) and is unable to file claim within 30 days of loss/incident such claim cases will be honored by HDFC
  Ergo if all terms under the policy are met as on date of loss. Here "date of loss" is the date on which incident has occurred.

- All supporting documents relating to the claim must be submitted within sixty (60) days from the date of loss.

- The claims will be settled in 10 working days from the date of receiving the complete documents set.

- In case documents are not received within 60 days of claim intimation, 1st reminder hard copy letter will be issued to Member Bank, followed by an email communication.

- 2nd reminder hard copy letter will be sent after 81 days from claim intimation followed by an email.

- Closure letter hard copy letter will be sent to Member Bank on 90th day from claim intimation in case of no communication received from Member Bank.

Investigator appointment

Based on the merit of the claim HDFC ERGO's investigation team shall be appointed.
TAT: T +3 (T is the day on which the claim documents received from the Member Bank)

In 30 days, Investigation report will be finalized. If there is a delay because of the some more facts, an interim report will be requested.

Claims Follow up / Processing

The reminders shall be sent to Member Bank in regular intervals for claim documents, a communication via letter in hard copy / email will be sent to client with defined timeline. Reminder process would be same for the documents deficiency also

1st reminder T+61

2nd reminder T+81

Closure Letter

T+90

T is Date of Intimation

Escalation Matrix

For claims

First level Contact
npcirupay@hdfcergo.com

Second level Contact
Mr. Parimal Machhi – Claims Manager
Email: npcirupay@hdfcergo.com
Contact: 9820789099

Third level Contact
Mr. Venkatrao Kulkarni
AVP – Claims
Email: venkatrao.kulkarni@hdfcergo.com
Contact: 9833097673, 022-66383600 extn:3229

Fourth level Contact
Mr. Vikram Kumar SinghKashayap Dakshini
Sr VP - Claims
Email: vikram.singh@hdfcergo.com
Contact: 08373915558

For Policy Administartion

First Contact
Amita Desai
VP - CBG
Email: amita.desai@hdfcergo.com
Contact : 9930266024

Second Contact
Sanjay Kaw
Executive VP- Corporate Business Group
Email: Sanjay.kaw@hdfcergo.com
Contact: 09930266037

Claim Payment

Once the claim is approved the payment in the form of **NEFT** shall be done to the card holder beneficiary along with a covering letter.

Document check list –

Accidental Death Claim: –

1) Duly filled and signed claim form
2) FIR copy
3) Post mortem report
4) "Cause of Death" certificate from treating doctor
5) Death Certificate – issued by a municipal authority
6) Viscera report (If done)
7) Passport, Pan Card, Aadhaar card, address proof (KYC documents)
8) Copy of the RuPay card / Declaration from Bank on letter head with sign and stamp
9) Switch Log / Core Banking System screenshot from Bank for Transaction verification
10) Declaration from Bank for nominee including NEFT details with sign and stamp (in case nominee is available) / legal heir certificate or any other document in discussion with claimant as a proof (in case nominee not available with bank)

Permanent Disability Claim: –

1) Duly filled and signed claim form
2) FIR copy
3) Disability certificate from treating doctor / Government hospital
4) Hospital Indoor case paper
5) Full size photo of insured with disable / Amputed limb
6) Passport, Pan Card, Aadhaar card, address proof (KYC documents)
8) Copy of the RuPay card / Declaration from Bank on letter head with sign and stamp
9) Switch Log / Core Banking System screenshot from Bank for Transaction Verification

Accidental Death

Claimant's Statement

Form 'E'

INSURED INFORMATION

Insured's Name_____ Date of Birth ___/____/____ Marital Status _____

Insured's Address _____

Name and address of Last Employer

_____

Policy Number _____ Insured's Occupation (at time of death) _____

Did the Insured have any other accident or life insurance? _____ If yes, please list all companies, policy numbers and insurance amounts:__ _____

CLAIM INFORMATION

Date of accident _____/_____/_____ Time and place accident occurred_____

Please describe in detail the circumstances of accident (attach separate sheet if needed):

_____

_____

Was the accident related to the Insured's occupation? _____ If so, how? _____

Please describe the cause of the Insured's death:

_____

Please list the names and addresses of all treating physicians and hospitals:_____

_____

Did police or other authorities investigate the accident? ____ If yes, please provide name, address and telephone number of all investigating officers and agencies: _____

Was an autopsy performed?_____ If yes, please provide name and address of Medical Examiner_____

_____

Was a coroner's inquest held? _____If yes, what was the determination?_____

CLAIMANT INFORMATION

Claimant's Name_____ Age_____ Relationship to Insured_____

Claimant's Address_____ Phone No. (H)_____

_____ Phone No. (W)_____

In what capacity are you making this claim? _____ Beneficiary _____ Executor* _____ Administrator* _____ Guardian* _____Trustee* _____Assignee*

*Please provide a certified copy of all documents supporting your authority (e.g., Succession Certificate, Notarised Affidavit, Notarised will, etc.)

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by HDFC ERGO General Insurance, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Place:

DATE ____/____/____

_____

SIGNED (Claimant or authorized person)

Accidental Injury Claim
Claimant's Statement

Form 'A'

INSURED INFORMATION

Insured's Name_____ Date of Birth ___/____/____ Marital Status ____

Insured's Address _____ Phone No. (Off)_____

_____ Phone No. (Res)_____

Name and address of employer _____

Policy Number _____ Insured's Occupation _____

Does the insured have any other insurance ? _____If yes, please list all companies, type of insurance, policy numbers and insurance amounts:_____

_____

CLAIM INFORMATION

Date of accident _____/_____/_____ Time and place accident occurred_____

Please describe in detail the circumstances of accident (attach separate sheet if needed): _____

_____

Was the accident related to the Insured's occupation? _____ If so, how? _____

Please describe the nature of Insured's injuries:_____

Please list the names and addresses of all treating physicians and hospitals:_____

_____

_____

Did police or other authorities investigate the accident? ____ If yes, please provide name, address and telephone number of all investigating officers and agencies: _____

CLAIMANT INFORMATION (If different than "Insured Information" above)

Claimant's Name_____ Age_____ Relationship to Insured_____

Claimant's Address_____ Phone No. (Off) _____

_____ Phone No. (Res)_____

In what capacity are you making this claim? _____

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by HDFC ERGO General Insurance, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.
SIGNED (Claimant or authorized person) _____ DATE ____/____/____

Accidental Injury Claim
Claimant's Statement

Form 'A'

INSURED INFORMATION

Insured's Name_____ Date of Birth ___/____/____ Marital Status ____

Insured's Address _____ Phone No. (Off)_____

_____ Phone No. (Res)_____

Name and address of employer _____

Policy Number _____ Insured's Occupation _____

Does the insured have any other insurance ? _____If yes, please list all companies, type of insurance, policy numbers and insurance amounts:_____

_____

CLAIM INFORMATION

Date of accident _____/_____/_____ Time and place accident occurred_____

Please describe in detail the circumstances of accident (attach separate sheet if needed): _____

_____

Was the accident related to the Insured's occupation? _____ If so, how? _____

Please describe the nature of Insured's injuries:_____

Please list the names and addresses of all treating physicians and hospitals:_____

_____

_____

Did police or other authorities investigate the accident? ____ If yes, please provide name, address and telephone number of all investigating officers and agencies: _____

CLAIMANT INFORMATION (If different than "Insured Information" above)

Claimant's Name_____ Age_____ Relationship to Insured_____

Claimant's Address_____ Phone No. (Off) _____

_____ Phone No. (Res)_____

In what capacity are you making this claim? _____

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by HDFC ERGO General Insurance, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Claimant or authorized person) _____ DATE ____/____/____

ANNEX - E

Declaration from the member bank (on bank's letter head)

(In case nominee details available with the member bank)

This is to hereby confirm that the Mr. / Ms. _____ was issued a RuPay card vide no. _____ issued by our bank, and as per the bank records the nominee details of the card holder is as mentioned below along with the NEFT details of the nominee.

Card Holder Name: _____

RuPay Card Type: _____

RuPay Card No:_____

Nominee Name:_____

Relationship with the nominee: _____

Bank Account No.: _____

IFSC Code:_____

Bank Branch Name:_____

Bank Address:

_____

Authorized signatory

Bank seal

Accidental Injury
Hospital Cash Claim (Accident or Sickness)
Attending Physician's Statement

Form 'D'

INSURED INFORMATION

Insured's Name_____ Date of Birth ____/____/___ Marital Status _____

Insured's Address_____ Phone No. (H)_____

_____ Phone No. (W)_____

Name and address of employer _____

Policy Number_____ Insured's Occupation _____

CLAIM INFORMATION

Date of accident: ____/ ____/____ Date of first treatment: _____/_____/_____

Please describe in detail the nature of the Insured's injuries,

_____

_____

Was the accident related to the Insured's occupation? _____ If so, how? _____

Was the Insured hospitalized? _____ If yes, please list the names and addresses of all hospitals and all admission/discharge dates:

_____

_____

Did the Insured have any injury or illness prior to the accident that contributed to the accident or to the Insured's present condition? ____
If yes, please describe: _____

_____

Were any surgical procedures performed? _____ If yes, please list all procedures, and dates performed:

_____

_____

What are the Insured's current subjective symptoms? _____

_____

What are the objective findings? (please include results of current x-rays, lab tests, etc.,)? _____

_____

Dates of total disability:

From: _____/_____/_____ To: ____/____/____

Dates of partial disability:

From: _____/_____/_____ To: _____/_____/_____

Date Insured able to return to work: _____/_____/_____

Was the Insured seen by any other physician? _____ If yes, please list the names and addresses of all other physicians: _____

_____

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician: _____ Phone No. _____

Address: _____

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Attending Physician) _____ DATE ____/____/____