

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED

The issuance of this Form is not to be taken as an admission of liability

SECTION E - DETAILS OF CLAIM:

a) Details of the other treatment expenses claimed

S.N.	Cover Name	Amount (in Rs)	S.N.	Cover Name	Amount (in Rs)
	Pre Hospitalization Expenses			Green channel benefit claim against Health wearable device	
	Post Hospitalization Expenses			Compassionate Visit in case of CI	
	Ambulance Cover			Vaccination for new born	
	Organ Donor Expenses			Out-patient Cover	
	Green channel benefit claim against Non payable expenses			Air Ambulance	

• For new born baby cover, separate claim form to be filled & submitted. • For Fitness Reward points, please fill separate form "Fitness reward earning claim form" available on our website. • Benefits under Cumulative Bonus, Early joining Benefit, Restoration of Sum Insured will be provided automatically. You need not file a claim separately for these.

b) Details of Lump sum / cash benefit claimed

S.N.	Cover Name	Claimed	S.N.	Cover Name	Claimed
	Hospital Cash	<input type="checkbox"/> Yes <input type="checkbox"/> No		Companion Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Loss of income benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No		Convalescence Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Enhanced Daily cash benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No		Benefit under Critical Illness optional Cover, if opted	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Home treatment additional daily Cash benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No		Benefit under Personal Accident optional Cover, if opted	<input type="checkbox"/> Yes <input type="checkbox"/> No

Amount as per above covers, if claimed by you, will be paid as per the terms and conditions of the Policy plan.

Check List of Claim Documents to be submitted (In original)* - Please (✓) tick relevant box

(For Hospital Cash benefit, photocopies of claim documents are acceptable)

<input type="checkbox"/> Claim Form duly filled and signed	<input type="checkbox"/> Copy of the Claim Intimation, if any	<input type="checkbox"/> Hospital Bill Payment receipt
<input type="checkbox"/> Hospital Main Bill	<input type="checkbox"/> Hospital Break-up Bill	<input type="checkbox"/> Doctor's request for investigation
<input type="checkbox"/> Hospital Discharge Summary	<input type="checkbox"/> Pharmacy Bill	<input type="checkbox"/> Operation Theatre Notes
<input type="checkbox"/> Investigation Reports (Including CT / MRI / USG / HPE / ECG)		<input type="checkbox"/> Test report and prescription relating to first consultation for the Illness
<input type="checkbox"/> Doctor's prescription for medicines purchased outside the hospital and investigation done outside hospital		<input type="checkbox"/> FIR / MLC in case of accident injury and English translation of the same if it is in any other language
<input type="checkbox"/> KYC document (Address proof, ID proof only for all claims)		<input type="checkbox"/> Original Death Summary (Wherever applicable)
<input type="checkbox"/> Cancelled cheque leaf of the bank account held in the name of the primary insured (Mandatory)		<input type="checkbox"/> Any Other

*Please retain copy of complete set of claim documents for your records

SECTION F - DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1.				Hospital Main Bill	
2.				Pre-hospitalisation Bills: Nos	
3.				Post-hospitalisation Bills: Nos	
4.				Pharmacy Bills	
5.					
6.					
7.					
8.					
9.					
10.					

Note: If there are more bills, please attach additional sheets with this claim form giving the bill details in same format as below.

Hospital Main Bill Payment Receipts only

Receipt No.	Date	Amount (Rs)	Please (✓) Tick Relevant Box	
			<input type="checkbox"/> Advance Receipt	<input type="checkbox"/> Final Receipt
			<input type="checkbox"/> Advance Receipt	<input type="checkbox"/> Final Receipt
			<input type="checkbox"/> Advance Receipt	<input type="checkbox"/> Final Receipt
			<input type="checkbox"/> Advance Receipt	<input type="checkbox"/> Final Receipt

Note: Please attach separate sheet if necessary

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GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
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 policyholder	Tick the right option. If others, please specify
f) Address	Enter the full postal address	Include Street, City and Pin Code
Phone No.	Enter the phone number of patient	Include STD code with telephone number
E-mail ID	Enter e-mail address of patient	Complete e-mail address
g) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify
i) Address of the Employer	Complete address of the employer of the Insured	Include Street, City and Pin Code
SECTION D - DETAILS OF HOSPITALISATION FOR CLAIM BEING FILED		
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) Hospitalisation due to	Indicate reason of hospitalisation	Tick the right option
d) Date of injury / Date disease first detected/ Date of delivery	Enter the relevant date	Use dd-mm-yy format
e) 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) In case of maternity		
i. Date of delivery	Enter date of delivery	Use dd-mm-yy format
ii. Gravida Status	Enter Gravida Status	Use standard format
j) If Injury give cause	Indicate cause of injury	Tick the right option
i. If Medico Legal	Indicate whether injury is Medico Legal	Tick Yes or No
ii. Reported to Police	Indicate whether police report was filed	Tick Yes or No
iii. MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
k) 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 Hospitalisation	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ Cash Benefit claimed	Enter the amount claimed as lump sum/ cash benefit	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 amounts in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
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) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd-mm-yy format), place (open text) and sign.		