

Claim Form - IndiaFirst Money Back Health Insurance Plan

Disclaimer: All claim payments would be made through the electronic fund transfer only.
(Issuance of this form does not amount to admission of any claim/liability under the policy on the part of the insurers.)

Details of the Life Assured with respect to whom the claim is made

Name of the Life Assured : F I R S T M I D D L E L A S T

Policy Number : _____

Date of Birth of the Life Assured : D D M M Y Y Y Y

Present Completed Age (In Years): _____

Gender : M F

Relationship with the Policyholder : _____

Address : _____
 _____ City _____
 _____ State _____ PIN _____

Mobile Number (Mandatory) : _____

Name of the Policyholder (Self / Main Member) : F I R S T M I D D L E L A S T

Email ID : _____

Nature of Disease/ Illness Contracted or Injury Suffered for which the Life Assured was

Hospitalized (Diagnosis) : _____

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

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

Date of injury sustained or disease/ illness first detected : D D M M Y Y Y Y

Do you have health insurance policy with any other insurance company? If yes, please provide the details:

Name of the Insurance Company : _____

Policy Number : _____

Policy Period : _____

Sum Assured : _____

Name of the Life Assured : F I R S T M I D D L E L A S T

Details of the Hospital/ Nursing Home in which treatment was done:

Name of the Hospital/ Nursing Home : _____

Address of the Hospital / Nursing Home: _____
 _____ City _____
 _____ State _____ PIN _____

Telephone Number/ Mobile Number : _____

Registration Number of the Hospital : _____

Room Category in which you were admitted (Tick whichever is applicable): Single Room Twin Sharing

Details of the attending Medical Practitioner / Doctor / Treating Physician or Surgeon

Name : _____

Qualification and Registration Number : _____

Address : _____
 _____ City _____
 _____ State _____ PIN _____

Telephone Number/ Mobile Number : _____

Details of the Amount Claimed

| Bill Head | Bill Amount (In Rs.) | Bill Date | Whether Document has been Submitted | |
|--|----------------------|-----------|-------------------------------------|----|
| | | | Yes | No |
| Room Rent | | | | |
| Doctors Consultation/ Visit Charges | | | | |
| Surgeon, Anesthetists, Medical Practitioner, Consultants, Specialists and Other Doctors' Fee | | | | |
| Investigation Charges (Including Radiology and Pathology) | | | | |
| Operation Theater Charges | | | | |
| Medicine Charges (Including Ward and OT Medicine and Consumables) | | | | |
| Total Amount Claimed | | | | |

Documents to be submitted along with this Form (Check List)

| Documents to be Submitted | Please Tick Whichever Document you have Submitted |
|---|---|
| 1. Copies of the policy schedule. | |
| 2. Signed claim form | |
| 3. First consultation letter | |
| 4. Original final bill and paid receipts with detailed breakdown of various billing categories | |
| 5. Original and complete discharge card/death summary mentioning duration of ailment and duration of other disorders/cause of death | |
| 6. Original investigation reports with corresponding prescription/ request | |
| 7. Pharmacy bill, if supplied by hospital with corresponding prescription/ request | |
| 8. Copy of identity proof | |
| 9. Pre/ post hospitalization bills with corresponding prescription/ request, if any | |
| Total Amount Claimed | |

The Company/ Third Party Administrator reserves the right to call for additional documents/ requirements.

Declaration and Authorization

I/ We authorize IndiaFirst Life /any court of law or any grievance redressal forum to gather/ collect any medical information regarding the my/our state of health which I/ we may have acquired before or after the issuance of the plan on their request from any employer, medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organization, institution or person, that has any records or knowledge of the patient and/or who has attended or may attend to me/us.

I also authorize IndiaFirst Life Insurance Company or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate my/our health status in relation to this claim.

I hereby confirm that this authorization is notwithstanding any law, custom or usage for the time being in force which prohibits any physician or hospital from divulging any knowledge or information, acquired by him/ them in attending upon or examining a person on the ground of secrecy.

A photocopy or facsimile copy of this authorization shall be as valid as the original.

Further, I/we hereby authorize any insurance company, government organization, employer, other organization, institution or person to release to IndiaFirst or its duly authorized representatives any record or knowledge about me/us. I hereby confirm that such information shall without limitation include information about my/our health (including any information relating to the use of drugs or alcohol, AIDS, or mental and physical history, condition, advice or treatment), earnings or other insurance benefits, including any accounting information relating to me/us.

I/ We also agree to render help to IndiaFirst or its duly authorized representatives to gather any information that may help the company to process this claim and to use the information in whatever manner as may be deemed to be fit to process this claim further.

I/We hereby declare that the above information stated in this form is true and correct to the best of my/our knowledge and belief. If I/we have made any false, fraud or untrue statement, suppression or concealment, my/our right to claim shall be forfeited.

I/we hereby declare that I/we have included all bills/ receipts for the purpose of this claim and I/we will not be making any supplementary claim in respect thereof.

| |
|-------------------------------|
| Signature of the Policyholder |
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| |
|-------------------------------|
| Signature of the Life Assured |
|-------------------------------|

Name of the Policyholder: _____

Name of the Life Assured : _____

Date :

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

Date :

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

Mode of Payment:

Mode selected would be used by the company to make payout(s) to the Claimant. Payout would be in accordance and subject to the terms and conditions of the policy. Please note that the claim payment will be made only through the following modes.

Direct Credit (Bank of Baroda and Andhra Bank only) NEFT / RTGS

| | | | |
|--------------------------|--|-----------------|--|
| Bank Name | | Branch | |
| Account Number | | Type of Account | |
| IFSC Code | | MICR Code | |
| Name as per Bank Records | | | |

Please provide a cancelled cheque and copy of bank pass book and A/C statement if any of the above payout options is selected.



Kindly mail this completely filled form along with the documents to:
 IndiaFirst Life Insurance Company Ltd.
 C/O E-Meditek (TPA) Services Limited
 Plot No 577, Udyog Vihar Phase V, Gurgaon -122016
 Fax No : 0124-4466677
 Toll Free Number: 1800 103 3232
 E-Mail : health.first@indiafirstlife.net

