



CLAIM FORM FOR HEALTH INSURANCE POLICY OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A  
TO BE FILLED IN BY THE INSURED  
The issue of this Form is not to be taken as an admission of liability

(To be filled in block letters)

Details of Primary Insured

a) Policy No:

b) Sl. No/ Certificate No:

c) Company/ TPA ID No:

d) Name:

e) Address:

City:

State:

Pin Code:

Phone No:

Email:

Details of Insurance History

a) Currently covered by any other Mediclaim / Health InsuranceYes ☐ No ☐

b) Date of commencement of first Insurance without break

c) If yes, company name:  Policy No:

Sum Insured (₹.)

d) Have you been hospitalized in the last four years since inception of the contract?Yes ☐ No ☐

Date:

Diagnosis:

e) Previously covered by any other Mediclaim / Health Insurance: Yes ☐ No ☐

f) If yes, Companys Name:

Details of Insured Person Hospitalized

a) Name:

b) Gender: Male ☐ Female ☐

c) Age: years  Months

d) Date of Birth:

e) Relationship to Primary insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ (Please Specify)

f) Occupation: Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ (Please Specify)

g) Address (if different from above):

City:

State:

Pin Code:

Phone No:

Email:

Details of Hospitalization:

a) Name of Hospital where Admitted:

b) Room Category occupied: Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐

c) Hospitalization due to: Injury ☐ Illness ☐ Maternity ☐

d) Date of Injury / Date disease first detected /Date of delivery:

e) Date of admission:

f) Time:

g) Date of discharge:

h) Time:

i) If Injury give cause: Self inflicted ☐ Road traffic accident ☐ Substance abuse/Alcohol consumption ☐

If Medico legal: Yes ☐ No ☐

ii. Reported to police: Yes ☐ No ☐

iii. MLC Report & Police FIR attached: Yes ☐ No ☐

j) System of Medicine:

Details of Claim

a) Details of the treatment expenses claimed

i. Pre-hospitalization expenses: ₹

ii. Hospitalization expenses: ₹

iii. Post-hospitalization expenses: ₹

iv. Health-Check up cost: ₹

v. Ambulance charges: ₹

vi. Others (code):  ₹

Total ₹

vii. Pre-hospitalization period: days

viii. Post-hospitalization period: days

b) Claim for domiciliary hospitalization: Yes ☐ No ☐ (If yes, provide details in annexure)

c) Details of lump sum/ Cash benefit claimed:

i. Hospital daily cash: ₹

ii. Surgical cash ₹

iii. Critical Illness Benefit: ₹

iv. Convalescence: ₹

v. Pre/Post hospitalization lump sum benefit: ₹

vi. Others:  ₹

Total ₹

Claim Documents Submitted- Check List:

☐ Claim Form duly signed

☐ Copy of claim intimation, if any

☐ Original Main Hospital Bill with Break Up

☐ Original Hospital Bill Payment Receipts

☐ Original and complete discharge card

☐ Original investigation bills/ receipts with original Investigation report

☐ Original Pharmacy bill with corresponding prescription/ request

☐ Copies of identity and age proofs of insured hospitalized

☐ Copy of Bank pass book/ statement of policyholder's (of nominee in case of death of Policyholder) personal account along with cancelled Cheque

Details of Bills Enclosed

| Sl. No | Bill No | Date                 | Issued by | Towards                            | Amount (₹) |
|--------|---------|----------------------|-----------|------------------------------------|------------|
| 1.     |         | <input type="text"/> |           | Hospital Main Bill                 |            |
| 2.     |         | <input type="text"/> |           | Pre-hospitalization Bills:____Nos  |            |
| 3.     |         | <input type="text"/> |           | Post-hospitalization Bills:____Nos |            |
| 4.     |         | <input type="text"/> |           | Pharmacy Bills                     |            |
| 5.     |         | <input type="text"/> |           |                                    |            |
| 6.     |         | <input type="text"/> |           |                                    |            |
| 7.     |         | <input type="text"/> |           |                                    |            |
| 8.     |         | <input type="text"/> |           |                                    |            |
| 9.     |         | <input type="text"/> |           |                                    |            |
| 10.    |         | <input type="text"/> |           |                                    |            |

Section A

Section B

Section C

Section D

Section E

Section F

## Section H \_\_\_\_\_ Section 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 TPA/ 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. I hereby declare that I have included all the bills/ receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date: 

|   |   |
|---|---|
| D | D |
|---|---|

|   |   |
|---|---|
| M | M |
|---|---|

|   |   |
|---|---|
| Y | Y |
|---|---|

 Place: 



 Signature of the Policy Holder 



 Signature of the Insured

CIF AR/Hlt/V1/Apr 20