IndiaFirst LIFE INSURANCE

PROMOTED BY Bank of Baroda | Andhra Bank

Claim Intimation form – Critical Illness

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.) Please attach this form fully completed along with "Treating Doctors Certificate" issued by appropriate Authority to help us process your claim promptly. IndiaFirst does not demand any kind of fees to process claims. Please connect with our customer service team at 1800 209 8700, if any such demand is made.

Life Assured's details

Name: Policy number:

Date of birth: D D M M Y Y Y Y Occupation:

Address:

City: Pin code: State:

E Mail ID: Mobile:

PAN No.:

Nature of Illness Suffered (Please tick the relevant illness for which you are filling the claim)

- ☐ Open Chest CABG (Coronary Artery Bypass Graft Surgery)
- ☐ Major Organ or Bone Marrow Transplant (as recipient)
- ☐ Open Heart Replacement or Repair of Heart Valves
- ☐ Motor Neurone Disease with Permanent Symptoms
- ☐ Kidney Failure requiring regular dialysis
- ☐ Stroke resulting in Permanent Symptoms
- ☐ Coma with Severity
- ☐ Alzheimer's Disease
- ☐ Heart attack
- ☐ Cancer

Other (Please Specify) _____

Details of Illness/Ailment

This section must be fully completed by the patient's treating doctor (Any fee for completion of this section is the responsibility of the insured person.)

Name of Patient

Name and Address of Hospital

Presenting complaints of illness / disease (With duration)

Final diagnosis

Past Medical History (Related / Unrelated with current illness along with duration)

Date of first Diagnosis of illness

Name and Degree of Treating doctor

Date of consultation / Admission

Treatment Given

Date of Admission (If Hospitalised) D D M M Y Y Y Y Date of Discharge (If Hospitalised) D D M M Y Y Y Y

Has the patient ever suffered with this or any similar condition before the present episode?

Employment/Occupation Details

Occupation Salaried ☐ Business ☐ Student ☐ Housewife ☐ Retired ☐

Name of the Company / Business

Address of the Company / Business

List of Job Duties

Are you currently Employed Yes ☐ No ☐ If "No", than last attended employment date D D M M Y Y Y Y

Please Give the Details of the Medical / Sick Leave taken in Last 5 Years

Dates		Reason as per Medical Certificate / Leave Application	Employer Mediclaim Benefit Availed (Yes / No) (If Yes provide TPA Name)
From	To		

Particulars of other Health Insurance / Mediclaim Policies held by the Life Assured

Name of the company / TPA	Policy Issue date	Sum assured	Claim Raised (Yes / No)	Policy No.	Illness / Disease

Declaration and Authorisation –

I hereby declare and confirm that I am the rightful claimant of this plan and that the details provided above are correct and true to the best of my knowledge. I have not withheld any relevant information and believe that I am the same person as the life assured under the plan issued by IndiaFirst Life Insurance Company Ltd.

Through this statement, I hereby authorize any hospital, institution, nursing home, medical clinic or medical practitioner who has treated or examined me for any kind of illness or ailment, to provide IndiaFirst/any court of law/ any grievance redressal forum with any medical information and documents regarding the Life Assureds state of health which he/she may have acquired before or after the issuance of the plan on its request. I also hereby authorize my past and present employer to share my employment and health benefit details. 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.

Further, I 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. Such information shall without limitation include information about my health (including any information relating to the use of drugs or alcohol, AIDS, Tuberculosis or mental and physical history, condition, advice or treatment), earnings or other insurance benefits, including any accounting information of the life assured's account. Lastly, I declare that I am entitled to make the above authorizations and agree to help IndiaFirst or its duly authorized representatives to gather any information and use it as may be deemed fit to help process this claim.

Mode of Payment (Mandatory to be Filled)

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.

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			

It is mandatory to provide a cancelled cheque and copy of bank pass book & A/C statement.

Disclaimer: The payout mode selected in this form would be used by the company to make all payout(s) to the claimant. Payouts would be in accordance and subject to the terms and condition of the policy.

I declare and state that the company shall not be responsible for non credit of my bank account for any reason whatsoever or if the credit is delayed. I hereby take the sole responsibility for the correctness of my Bank Account number and other details of this form. I undertake that I will not hold the company responsible in any manner for any transactions affected by the company due to incorrect Bank Account No. Or these details stated by me.

Name of Claimant/Policy holder: _____ Location: _____

Contact Details: _____

Name and Signature of Claimant/Policy holder

Witness Authorization (Required where Owner/ Proposer has provided Thumb Impression / Signature in Vernacular Language)

Content of this form and its particulars has been explained by me in vernacular language to the Owner/ Proposer

Name of Witness: _____ Relationship with Claimant: _____

Contact Details: _____ Place: _____ Date: D D M M Y Y Y Y

Name and Signature of Witness:

Claims process requirements

S. No	List if Mandatory Documents required	Tick whichever Submitted
1	Critical Illness Claim Form	
2	Treating Doctors Certificate	
3	Heart attack - ECG, Cardiac Enzyme Test Report	
4	CABG - Surgical Notes and Angiography Reports	
5	Cancer - Histopathology / Biopsy Report	
6	Stroke - CT- SCAN, MRI Report and Neurologist Report	
7	Major Organ Transplant - Diagnosis of Original Report, Surgical Summary, Discharge Card	
8	Self attested Copy of bank pass book of Policy Holder along with cancelled cheque with preprinted name	

The company may call for any additional document or information that may be needed to process the claim depending on the cause or nature of claim. Kindly mail this completely filled form along with the documents to:

IndiaFirst Life Insurance Company Ltd.,
12th and 13th Floor, North [C] Wing, Tower 4, Nesco IT Park, Nesco Center,
Western Express Highway, Goregaon (East), Mumbai – 400063,
CIN: U66010MH2008PLC183679.

Tel: +91 22 6165 8700 **Fax:** +91 22 6857 0600 **Toll Free:** 1800-209-8700

E-mail: customer.first@indiafirstlife.com **Website:** www.indiafirstlife.com