







	(To be filled in block letters)
D	Details of Primary Insured
a)	Policy No: b) SI. No/ Certificate No:
c)	Company/ TPA ID No:
d)	Name: S U R N A M E F I R S T N A M E M I D D L E N A M E
e)	Address:
	City: State:
	Pin Code: Phone No: Email:
D	Details of Insurance History
a)	Currently covered by any other Mediclaim / Health InsuranceYes No
b)	Date of commencement of first Insurance without break D D M M Y Y
c)	If yes, company name: Policy No: Policy No:
	Sum Insured (₹.) d) Have you been hospitalized in the last four years since inception of the contract? es No
	Date: M M Y Y Diagnosis: e) Previously covered by any other Mediclaim / Health Insurance: Yes No
f)	If yes, Companys Name:
D	Details of Insured Person Hospitalized
a)	Name: S U R N A M E F I R S T N A M E M I D D L E N A M E
b)	Gender: Male Female c) Age: years Y Y Months M M d) Date of Birth: D D M M Y Y
e)	Relationship to Primary insured: Self Spouse Child Father Other (Please Specify)
f)	Occupation: Service Self Employed Homemaker Student Other (Please Specify)
g)	Address (if different from above):
	City: State:
	Pin Code: Phone No: Email:
D	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: D D M M Y Y
e)	Date of admission: DD MM MYY f) Time: HH: MM g) Date of discharge: DD MM MYY
h)	Time: H H : M M 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:
D	Details of Claim
	Details of the treatment expenses claimed Claim Documents Submitted- Check List:
	Details of the treatment expenses claimed i. Pre-hospitalization expenses: ₹
1)	Details of the treatment expenses claimed i. Pre-hospitalization expenses: ₹ ii. Hospitalization expenses: ₹ iii. Hospitalization expenses: ₹ iv. Health-Check up cost:
)	Details of the treatment expenses claimed i. Pre-hospitalization expenses: ₹ ii. Hospitalization expenses: ₹ iv. Health-Check up cost: ₹ Original Main Hospital Bill Payment Receipts
1)	Details of the treatment expenses claimed i. Pre-hospitalization expenses: ₹ ii. Hospitalization expenses: ₹ Claim Documents Submitted- Check List: Claim Form duly signed Copy of claim intimation, if any Copy of claim intimation, if any Original Main Hospital Bill with Break Up
1)	Details of the treatment expenses claimed i. Pre-hospitalization expenses: ₹ ii. Hospitalization expenses: ₹ Claim Form duly signed Copy of claim intimation, if any Original Main Hospital Bill with Break Up Original Hospital Bill Payment Receipts Total ₹ Original and complete discharge card Original investigation bills/ receipts with original Investigation report
))	Details of the treatment expenses claimed i. Pre-hospitalization expenses: ₹ ii. Hospitalization expenses: ₹ ii. Hospitalization expenses: ₹ ii. Hospitalization expenses: ₹ iv. Health-Check up cost: ₹ iv. Health-Check up cost: ₹ iv. Health-Check up cost: ▼ iv.
i)))	Details of the treatment expenses claimed i. Pre-hospitalization expenses: ₹
n)))	Details of the treatment expenses claimed i. Pre-hospitalization expenses: ₹
a) c)	Details of the treatment expenses claimed i. Pre-hospitalization expenses: ₹ ii. Hospitalization expenses: ₹ Claim Form duly signed Copy of claim intimation, if any Original Main Hospital Bill with Break Up Original Main Hospital Bill with Break Up Original Hospital Bill Payment Receipts Total ₹ Original and complete discharge card Original investigation bills/ receipts with original Investigation bills/ receipts with original Investigation report Original Pharmacy bill with corresponding prescription/ request Original Pharmacy bill with original Pharmacy bill with prescription Origin
a) c)	Details of the treatment expenses claimed i. Pre-hospitalization expenses: ₹ ii. Hospitalization expenses: ₹ Claim Form duly signed iii. Post-hospitalization expenses: ₹ ii. Hospitalization expenses: ₹ Claim Form duly signed Copy of claim intimation, if any Original Main Hospital Bill with Break Up Original Hospital Bill with Break Up Original Hospital Bill Payment Receipts Original and complete discharge card Original investigation bills/ receipts with original Investigation report Original Investigation report Original Pharmacy bill with corresponding prescription/ request Copy of Bank pass book/ statement of Copy of Bank pass book/ statement of 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 with Break Up Original Investigation bills/ receipts with 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 Claim Form duly signed Copy of Bank pass book/ statement of Copy of Bank pass book/ statement of Copy of Bank pass book/ statement of Claim Form duly signed Copy of Bank pass book/ statement of Copy of Bank pass book/ statement of Claim Form duly signed Copy of Bank pass book/ statement of Claim Form duly signed Copy of Bank pass book/ statement of Claim Form duly signed Copy of Bank pass book/ statement of Claim Form duly signed Copy of Bank pass book/ statement of Claim Form duly signed Copy of Bank pass book/ statement of Copy of Bank pass book/ statement of Claim Form duly signed Copy of Bank pass book/ statement of Claim Form duly signed Copy of Bank pass book/ statement of Claim Form duly signed Claim Form

SI. No	Bill No	Date	Issued by	Towards	Amount (₹)
1.		D D M M Y Y		Hospital Main Bill	
2.		D D M M Y Y		Pre-hospitalization Bills:Nos	
3.		D D M M Y Y		Post-hospitalization Bills:Nos	
4.		D D M M Y Y		Pharmacy Bills	
5.		D D M M Y Y			
6.		D D M M Y Y			
7.		D D M M Y Y			
8.		D D M M Y Y			
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a)	Name as per Bank Records:							
b)	PAN: c) Type of Acco	unt						
d)	Account number:							
e)	Bank name and Branch:							
f)	Cheque/ DD Payable details:	g)	IFSC Code					

Declaration By The Insured

Details of Primary Insured's Bank Account

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.

		er Signature of the Insured					
	Guidance For Filling Claim Form - Part A (To be fille	ed in by the insured)					
Data Element	Description	Format					
	Section A - Details of Primary Insu	red					
a) Policy No.	Enter the policy number	As allotted by the insurance company					
b) SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization					
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documen					
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name					
e) Address	Enter the full postal address	Include Street, City and Pin Code					
	Section B - Details of Insurance His	tory					
a) Currently covered by any other Mediclaim/ Health Insurance?	Indicate whether currently covered by another Mediclaim/ Health Insurance	Tick Yes or No					
b) Date of commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format					
c) Company Name	Enter the full name of the insurance company	Name of the organization in full					
Policy No.	Enter the policy number	As allotted by the insurance company					
Sum Insured	Enter the total sum insured as per the policy	In Rupees					
d) Have you been Hospitalized in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No					
Date	Enter the date of hospitalization	Use mm-yy format					
Diagnosis	Enter the diagnosis details	Open Text					
e) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No					
f) Company Name	Enter the full name of the insurance company	Name of the organization in full					
	Section C - Details of Insured Person Ho						
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) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.					
g) Address	Enter the full postal address	Include Street, City and Pin Code					
h) Phone No	Enter the phone number of patient	Include STD code with telephone number					
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address					
, =	Section D - Details of Hospitalizat						
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) Hospitalization due to	Indicate reason of hospitalization	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					
If Injury give cause	Indicate cause of injury	Tick the right option					
If Medico legal	Indicate whether injury is medico legal	Tick Yes or No					
Reported to Police	Indicate whether police report was filed	Tick Yes or No					
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No					
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text					
	Section E - Details of Claim						
	Enter the amount claimed a s treatment expenses	In Rupees (Do not enter paise values)					
a) Details of treatment expenses							
a) Details of treatment expenses	<u>'</u>	n Tick Yes or No					
b) Claim for domiciliary hospitalization	Indicate whether claim is for domiciliary hospitalization						
<u> </u>	Indicate whether claim is for domiciliary hospitalizatio Enter the amount claimed a s lump sum/ cash benefit Indicate which supporting documents are submitted	In rupees (Do not enter paise values) Tick the right option					
b) Claim for domiciliary hospitalization c) Details of Lump sum/ cash benefit claimed	Indicate whether claim is for domiciliary hospitalization Enter the amount claimed a slump sum/cash benefit Indicate which supporting documents are submitted Section F - Details of Bills Enclose	In rupees (Do not enter paise values) Tick the right option					

IndiaFirst Life Insurance Company Ltd.,

b) PAN

c) Type of Account

d) Account Number

g) IFSC Code

e) Bank name and branch

f) Cheque/DD payable details

301, 'B' Wing, The Qube, Infinity Park, Dindoshi - Film City Road, Malad (East), Mumbai - 400 097, CIN: U66010MH2008PLC183679.

Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.

Enter the permanent account number

Enter the bank name along with the branch

Enter the IFSC code of the bank branch

Enter the name of the beneficiary the cheque/

Section H - Declaration By The Insured

Account Type - Saving/ Current

Enter the bank account number

DD should be made out to

Please refer your policy documents for the Name and complete Address of your TPA for submitting your claim documents.

Tel: +91 22 6165 8700 Fax: +91 22 6270 0600 Toll Free: 1800-209-8700

As allotted by the Income Tax department

Name of the individual / organization in full

IFSC code of the bank branch in full

Open Text

As allotted by the bank

Name of the bank in full

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