IFFCO-TOKIO General Insurance Company Limited

CLAIM FORM - 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) SI. No./Certificate No.	
c) Company/TPA ID No.			
d) Name			
e) Address			
	City		
	State		Pin Code
	Ph. No.	Email ID	

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim/Health Insurance				Yes	No
b) If yes, Company Name					
Policy No.		Sum Insured (`)			
c) Date of commencement of first Insurance without break	DD / MM / YYYY	(Copies of Policies to be attached)			
d) Have you been hospitalized in the last 4 years? (since inception of the contract)	Yes	No	Date	DD / MM / YYYY	
	Diagnosis				
e) Have you been covered by any other Mediclaim/Health Insurance in last 4 years				Yes	No
f) If yes, Company Name					

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name								
b) Gender	Male	Female	c) Age	years	months	d) Date of Birth	DD / MM / YYYY	
e) Relationship to Primary insured	Self	Spouse	Child	Father	Mother			
	Other	(Please Specify)						
f) Occupation	Service	Self Employee	Homemaker	Student	Retired			
	Other	(Please Specify)						
Address (if different from above)								
City								
State				Pin Code				
Ph. No.	Email ID							

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 of Disease first detected/Date of Delivery	DD / MM / YYYY										
e) Date of Admission	DD / MM / YYYY	f) Time	HH	MM	g) Date of Discharge	DD / MM / YYYY	h) Time	HH	MM		
i) If injury give cause	Self inflicted	Road Traffic Accident									
Substance Abuse/Alcohol consumption		i. if Medico legal	Yes	No							
ii. Reported to police	Yes	No	iii. MLC Report & Police FIR attached	Yes	No						
j) System of Medicine											
k) Date of Surgery	DD / MM / YYYY	l) Claim Intimated	Yes	No							
i. Intimated to whom	SBU	Intermediaries	Call Centre	Health Claims Team							
ii. Intimation No. & date	DD / MM / YYYY										
iii. If not Intimated, reason?											

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)	`
vii. Pre-hospitalization period	days	**Total**	`
		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	☐	Operation Theatre Notes	☐
Copy of the claim intimation	☐	ECG	☐
Hospital Main Bill	☐	Doctor's request for investigation	☐
Hospital Break - up Bill	☐	Investigation Reports (CT/MRI/USG/HPE)	☐
Hospital Bill Payment Receipt	☐	Doctor's Prescriptions	☐
Hospital Discharge Summary	☐	Pre-Hosp. Bills	☐
Pharmacy Bill	☐	Post-Hosp. Bills	☐
		Others	☐

DETAILS OF BILLS ENCLOSED

Sl. No.	Bill No.	Date	Issued by	Towards (Hospitalization/Pre-hospitalization/ Post-hospitalization	Amount (`)
1		DD / MM / YYYY			
2		DD / MM / YYYY			
3		DD / MM / YYYY			
4		DD / MM / YYYY			
5		DD / MM / YYYY			
6		DD / MM / YYYY			
7		DD / MM / YYYY			
8		DD / MM / YYYY			
9		DD / MM / YYYY			
10		DD / MM / YYYY			

Do you want to opt for Automatic Reinstatement of Sum Insured in the event of a claim? If, Yes, applicable premium at short period rates would be deducted from the claim amount due to you. This reinstated sum will not be available for the same hospitalization. It will be available for treatment (other than certain chronic diseases) including the same illness or disease but separate independent case of hospitalization which are not case of relapse within 45 days of first hospitalization. Please contact the agent/our office for further details: Yes ☐ No ☐

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT (Please submit a cancelled cheque copy for NEFT)

a) PAN		b) Account Number	
c) Bank Name and Branch			
d) Cheque/DD Payable details		e) IFSC Code	

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.

Place:_____ Date: DD /MM/ YYYY

Signature of the Insured

Important:

1. Please submit copy of valid Photo ID.
2. For claimed amount above 1 lac, it is mandatory to submit the KYC (Know your customer) form.