Call (Toll Free)
1800 22 1111 | 1800 102 1111
www.sbigeneral.in

GROUP HEALTH INSURANCE POLICY

Claim Form

Issuance of this form does not amount to admission of any liability or a waiver of any of the terms and conditions of the insurance contract. If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or any Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy shall be void and all benefits paid under it shall be forfeited.

Claim No.

A. DETAILS OF INSURED/CLAIMANT

1. Name of the Insured (SURNAME MIDDLENAME FIRSTNAME)
2. Name of the Claimant (SURNAME MIDDLENAME FIRSTNAME)
3. Relationship with Insured — Date of Birth (DD MM YYYY)
4. Gender ☐ Male ☐ Female
5. Contact Details
   - House No. — Block
   - Building — Locality
   - Street
   - City — District
   - State — Pincode
   - Phone No. — Mobile
   - Email ID

B. DETAILS OF POLICY

1. Policy No. — Health Card No.
2. Period of insurance — From (DD MM YYYY) To (DD MM YYYY)
3. Employee No. — Group / Company Name

C. DETAILS OF OTHER POLICY

1. Is the illness / disease covered under any other Insurance? ☐ Yes ☐ No

   If 'Yes', please enclose photocopies of all previous policies

   - Name of Insurer
   - Policy No. — Name of TPA
   - Period of insurance — From (DD MM YYYY) To (DD MM YYYY) — Sum Insured

D. DETAILS OF PREVIOUS HEALTH CLAIM

1. Have you incurred any claim before? ☐ Yes ☐ No

   If 'Yes', please provide details

   - Previous Claim No.
   - Diagnosis
   - Date of admission (DD MM YYYY) — Date of Discharge (DD MM YYYY)
   - Paid ☐ Yes ☐ No — Amount settled
   - Repudiated ☐ Yes ☐ No

   If Yes, reason for Repudiation _____

Corporate & Registered Office: 'Natraj', 101, 201 & 301, Junction of Western Express Highway & Andheri - Kurla Road, Andheri (East), Mumbai - 400 069.

E. DETAILS OF ILLNESS/ACCIDENT

1. Nature of disease/illness/injury
2. Signs and symptoms of illness
3. Diagnosis of illness
4. When did you first notice signs and symptoms of the illness? (D D M M Y Y Y Y)
   When did you first consult your doctor for the illness? (D D M M Y Y Y Y)
5. When was the illness first diagnosed/detected? (D D M M Y Y Y Y)
6. Have you ever had the similar illness in past? ☐ Yes ☐ No
   If 'Yes', provide details,
7. Any other illness in the past?
8. Name of the Doctor consulted first for this illness
9. Contact Details of the Doctor
   Phone No. Mobile
   E-mail Id
10. Date & Time of Admission (D D M M Y Y Y Y) (:) A.M. / P.M.
11. Date & Time of Discharge (D D M M Y Y Y Y) (:) A.M. / P.M.
12. Type of Admission ☐ Emergency ☐ Planned ☐ Daycare
13. Type of Claim ☐ Hospitalization ☐ Pre Hospitalization ☐ Post Hospitalization
14. Type of Hospital ☐ Network ☐ Non-Network
15. Type of Treatment ☐ Allopathic ☐ Ayurvedic ☐ Homeopathic ☐ Unani ☐ Other

F. DETAILS OF HOSPITAL

1. Name of the Hospital
2. Address of the Hospital
   House No. Block
   Building Locality
   Street
   City District
   State Pincode
3. Name of treating Doctor
4. Qualification of treating Doctor
   Treating Doctors Registration No.
5. Contact Details
   Phone No. Mobile
   E-mail ID

Place

Date (D D M M Y Y Y Y)

Stamp and Signature of the treating Doctor

G. DETAILS OF CURRENT CLAIM BILLS

Sr. No.	Expense Details	Amount (Rs.)
A	Pre-hospitalization Expenses	
B	Hospitalization Expenses	
C	Post-hospitalization Expenses	
D	Day Care Hospitalization	
E	Ambulance Expenses	
F	Maternity Expenses	
G	Domiciliary Treatment expenses	
H	Dental Expenses	
I	Other expenses not included above	
J	Other expenses not included above	
	Total Amount Claimed	

Description	Claimed Amount (Rs.)
Room, Board and Nursing Expenses (No. of days x Amount / day)	
Intensive Care Unit Expenses (No. of days x Amount / day)	
Investigations Expense	
Medicines Expense	
Doctor Consultation / Visit Expense	
Surgeon Expense	
Anesthetist Expense	
Operation Theatre Expense	
Consumables Expense	
Registration / Service Expense	
Ambulance Expenses	
Other Expenses not included above	
Other Expenses not included above	
Other Expenses not included above	
GRAND TOTAL	

H. ENCLOSURE CHECKLIST

- ☐ Claim Form duly filled & signed
- ☐ Discharge Card / Certificate
- ☐ Hospitalization Bills
- ☐ Medicine Bills
- ☐ Investigation Bills
- ☐ Valid Photo Identity Card
- ☐ Medical Certificate
- ☐ FIR/ MLC copy
- ☐ Investigation Reports
- ☐ Any other documents
- ☐ Doctor's Prescription
- ☐ Any other documents, please specify ______________________________

____

I. DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

Pan Card No. ______________ Account No. ______________

Bank and Branch Name ______________

Cheque/ DD payable details ______________

Indian Financial System Code (IFSC) ______________

J. DETAILS OF OTHER INFORMATION

1. Do you wish to provide any other information? ☐ Yes ☐ No

   If 'Yes', specify ______________________________

____

I/We, the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect; and I/We agree that if I/We have made, or make in any further declaration, the Company may require in respect of the said accident, any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited, and the Policy shall be null and void, and all rights to recover there under in respect of past or future loss/accident shall be forfeited.

Place

Date: D D M M Y Y Y Y

Signature of Claimant

Name of Insured/Claimant

K. DETAILS TO BE FILLED BY HOSPITAL

1. Name of the patient

IP Registration No.

	ICD 10 codes	Description
a. Primary Diagnosis		
b. Additional Diagnosis		
c. Co-morbidities		
d. Co-morbidities		
e. Procedure 1		
f. Procedure 2		
g. Procedure 3		
h. Details of Procedure		

2. Pre-authorization Obtained ☐ Yes ☐ No

If Yes, Pre-authorization No.

If authorization is not obtained by network hospital please give reason

Is Hospitalization due to injury? ☐ Yes ☐ No

If Yes, ☐ Self inflicted ☐ RTA ☐ Any Other

If injury due to substance abuse / alcohol consumption? ☐ Yes ☐ No

Is test conducted to establish substance abuse? ☐ Yes ☐ No

Medico legal ☐ Yes ☐ No

Reported to police ☐ Yes ☐ No

FIR No.

If not reported to Police give reason

We hereby declare that information furnished in this form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact our right to claim under this claim shall be forfeited.

Place

Date: D D M M Y Y Y Y

Stamp and Signature of the Hospital Authority