Life Insurance

Aditya Birla Sun Life Insurance Company Limited

ADITYA BIRLA CAPITAL

PROTECTING INVESTING FINANCING ADVISING

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. Sl. No./Certificate No:

c. Company/ TPA ID No:

d. Name of Insured:

City: State:

Pin Code: Phone No: Email ID: _____

PAN: AADHAR Number (UID):

DETAILS OF INSURANCE HISTORY

a. Currently covered by any other Mediclaim / Health Insurance: Yes ☐ No ☐

b. Date of commencement of first Insurance without break: D D M M Y Y Y Y

c. If yes, company name Policy No.:

Sum Insured (Rs.):

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

Date: D D M M Y Y Y Y Diagnosis:

e. Previously covered by any other Mediclaim / Health insurance: 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: D D M M Y Y Y Y

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

f. Occupation: Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐

g. Address:

City: State:

Pin Code: Phone 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 Disease first detected /Date of Delivery: D D M M Y Y Y Y

e. Date of Admission in Hospital: D D M M Y Y Y Y f. Time: H H M M

g. Dale of Discharge: D D M M Y Y Y Y h. Time: H H M M Date of Admission in ICU: D D M M Y Y Y Y

i) Time: H H M M ii) Date of Discharge from ICU: D D M M Y Y Y Y iii) Time: H H M M

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: _____

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

i. Pre-hospitalization Expenses: Rs.
ii. Hospitalization Expenses: Rs.
iii. Post-hospitalization Expenses: Rs.
iv. Health Check up Cost: Rs.
v. Ambulance Charges: Rs.
vi. Other (code) Rs.
Total Rs.
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: Rs.
ii. Surgical Cash: Rs.
iii. Critical Illness Benefit: Rs.
iv. Convalescence: Rs.
v. Pre/Post hospitalization Lump sum benefit: Rs.
vi. Others Rs.
Total Rs.

Claim Documents Submitted - Check List

- ☐ Claim Form Duly signed
- ☐ Copy of Claim intimation, if any
- ☐ Hospital Main Bill
- ☐ Hospital Break-up Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bill
- ☐ Operation Theatre Notes
- ☐ ECG
- ☐ Doctor's request for investigation
- ☐ Investigation Reports (including CT/MRI/USG/HPE)
- ☐ Doctor's Prescriptions
- ☐ Others

DETAILS OF BILLS ENCLOSED:

Sr No	Blii No	Date (DDMMYY)	Issued by	Towards	Amount (Rs)
1				Hospital Main Bill	
2				Pre hospitalization Bills: _ Nos.	
3				Post Hospitalization Bills:_ Nos.	
4				Pharmacy Bills	
5					
6					
7					
8					
9					
10					

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN:
b) Account Holder Name:
(as mentioned in Bank Account)
c) Bank Account Number:
d) Bank Name:
Branch Name: Types of Bank Account:
Branch Address:
g) MICR code 9 digit as appearing on the cheque copy issued by bank:
h) IFSC code (Indian Financial Security code):
i) Cheque/ DD Payable details:

Please attach Pre Printed Cancelled Cheque bearing the above mentioned Account Number and IFSC Code along with this form. In case of non availability of Pre Printed Cancelled Cheque, Aditya Birla Sun Life Insurance Company Limited (ABSLI) requires a bank statement or a Printed Bankers Authorization in original containing aforesaid details duly seal and signed by Bank Branch Manager. In case of submission of incomplete / incorrect form Company will not transfer the Claim Proceeds Electronically and provide an account payee cheque mentioning account number and bank name if provided in the mandate or else company will draw an account payee cheque in case of admissibility of claim.

DECLARATION:

I/We hereby

- Declare that the details provided as above are correct andcomplete.
- Authorize Aditya Birla Sun Life Insurance Company Limited (ABSLI) to process the proceeds under the death claim of the aforesaid policy/s through EFT to the above mentioned account details
- Agree to not hold Aditya Birla Sun Life Insurance Company Limited (ABSLI) or its associate / agent responsible in case of any non credit to my bank account or if the transaction is delayed or not effected at all for reasons of error/misrepresentation/ incomple/tinecorrectinformation furnished by me in this EFT mandate.

PEP - State whether the Policy owner is a Politically Exposed Person Yes ☐ No ☐

PEP. "Individuals who are or have been entrusted with prominent public functions, for example Heads of State or government, senior politicians, senior government, judicial or military officials, Senior executives or state - owned corporation and important political part officials. Business relationship with family members or close associates of PEP's involving reputation risk is similar to those with PEP's themselves".

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in this claim form is true & correct. 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 heareby 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-hospitalizationclaim, if any. I hereby provide my consent to receive call from Aditya Birla Sun Life Insurance Company Limited (ABSLI) or its authorized Service Providers in connection with any matter related to my above claim and Policy.

Date: D D M M Y Y Y Y Place: _____

_____
Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF PRIMARY INSURED		
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) CompanyTPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documen ts.
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 HISTORY		
a) Currently covered by any other Mediclaim / HealthInsurance?	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/ HealthInsurance?	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 HOSPITALIZED		
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 HOSPITALIZATION		
a) Name of Hospital where admitted	Enter the name of hospttal	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 hospttalization	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
i) 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		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
d) Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option

SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amounts in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Account Holder Name	Enter the Account holder name	As allotted by the bank
c) Account Number	Enter the bank account number	As allotted by the bank
d) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
e) Type of Bank Account	Enter the type of bank account	As allotted by the bank
f) Branch Address	Enter the address of the bank	As per the branch address
g) MICR Code	Enter the 9 digit code as appearing on the cheque copy	As per the cheque
h) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
i) Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		