## **CLAIM FORM**

# KUTUMB SWASTHYA BIMA POLICY - Group



(To be filled in block letters)

A. DETAILS OF PRIMARY INSU	RED	)																												
Policy No:											]		Cla	im	No	:														
Family ID:			Customer/Member ID:																											
Period of Insurance:	From: D D M M Y Y Y Y D D M M Y Y Y																													
B. DETAILS OF INSURANCE HISTORY																														
a) Currently covered by any othe	a) Currently covered by any other Mediclaim / Health Insurance: Yes No																													
b) Date of commencement of firs	st In:	sur	anc	e w	itho	outb	ore	eak:																						
c) If yes, Company Name:																														
Policy No.:																			Su	ım	Ins	ure	d (R	s.):						
l) Have you been hospitalized in the last four years since inception of the contract?Yes No Date: D M M Y Y Y Y											Y																			
Diagnosis:																														
e) Previously covered by any other Mediclaim/Health insurance : Yes 📃 No 📄 f) If yes, Company Name:																														
A. DETAILS OF INSURED/CLA	IMA	NT																												
1. Name of Proposer/Claimant/ I	<sup>2</sup> rim	ary	Ins	ure	d:																									
2. Name of Guardian in case nom	ninee	e is	min	or:																										
3. Name of Insured (for whom cla	aim i	s re	gisi	tere	ed):																									
4. Relationship to Primary insured: Self Spouse Child Father Other Other																														
						(Ple	as	e Sp	bec	ify)_																				
Address:																														
		-																				Pir		de:						
Contact Details:	Pho	ne	No.														Μ	obi	le:											
	E-m	nail	ld:							_							Da	ate	ofE	Birt	th:		D	D	Μ	Μ	Y	Y	Y	Y
	Ger	nde	r: N	1ale			Fe	ema	ale				A	ge:	yea	ars	;			] n	non	ths			]					
Name & address of policy owner																														
(Bank/Group):																														
																						Pir		de:						
	Pho -			:														bil			<u> </u>									
	E-m						_				1						r	te	of B	-			D	D	Μ	Μ	Y	Y	Y	Y
	Ger	nde	r: N	1ale			Fe	ema	ale				A	ge:	yea	ars	; [			m	non	ths			]					
<b>B. WHAT BENEFIT DO YOU CL</b>	AIM	?																												
Personal Accident:	Dea	ath				Dis	sab	oility	/ [																					
Hospital Daily cash:	For	inju	Jry			For	r IIII	nes	s																					

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C. Fill details For PERSONAL ACCIDENT C	LAI	M																					
1. Date of accident:		D	D	M	M	Y	Y	Y	Y	]													
2. Date of Death (if applicable):		D	D	M	M	Y	Y	Y	Y	]													
3. Cause & Details of accident:										1													
4. Accident location:																							
5. Has the loss been reported to Police: Ye	es [		No	$\sim$	]											I		1					
If yes, Name & address of police station																							
If No, reason for not reporting		1																				 	
6. Was the person moved to hospital immedia	atel	v aft	er ti	he a		den <sup>.</sup>	t?		Y	′es			No		7								
(If Yes, Provide hospital treatment records)		,					-						-		<u> </u>								
7. In case of Permanent Total Disability Mentio	ion r	natu	re o	f dis	abi	litv																 	
a. Nature of disability																						 	
b. Is the claimed disability certified by Compe	eten	L t Go	⊥ vt A	⊥ \uth	orit	tv: Y	/es		 ] N			1											
D. Fill details for HOSPITAL DAILY CASH B	ENE	FIT	CL													1	1	1	1	1			
1. Diagnosis of illness/injury:																							
2. Date of 1st diagnosis:	D	M	Μ	Y	Y	Y	Y																
3. Name of Treating Doctor:																							
4. Name & address of hospital:																							
																	Pir	ncod	de:				
5. Date of admission:		M	$\mathbb{M}$	Y	Y	Y	Y			Date of Discharge: D D M M Y Y Y											Y		
6. Have you ever had the similar illness in past: Yes No																							
If Yes, provide details of diagnosis & treatmer	If Yes, provide details of diagnosis & treatment:																						
Name & contact detail of Treating doctor																							
E. PAYEE DETAILS (*All fields are mandato	rv /	Plea	ase	enc	lose	e ca	nce	ellec	d ch	ea	ue d	on	V)										
1. Payable To: Policy Holder Primary Ins	-	_				nine	Г						<i>.</i>										
Name of Guardian in case of minor nominee:	_																						
3. Proof of Bank Account Details provided: Ca							D-		ook														
				eque			Гc							. [				1	1	1			
4. Bank Name:							$\pm$	+					nch	1:   									
Bank Account No.:					-+		+	+				Coc		[									
MICR No.:												١N											
-	I/We hereby declare and warrant the truth of the foregoing particulars in every respect. I /We agree that if I/We have made or shal make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited.										hall												

I/We also hereby declare that I am/we are accepting the amount in full discharge of your obligations under the policy to the Insured Person and /or his/her legal heirs. I/we will hold you indemnified in the event of any claim under this policy being made against you by any other person or persons

### F. ANY OTHER INFORMATION YOU MAY WISH TO PROVIDE

Declaration: I hereby declare that the information furnished in this claim form is true and 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 and 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 and that I will not be making any supplementary claim except the pre/post-hospitalization claims, if any (for indemnity policies only). I/We also hereby declare that I am/we are accepting the amount in full discharge of your obligations under the policy to the Insured Person and /or

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Place: D D M M Y Y Y Y Date:	Name of Cla	Signature of Claimant:
ANNEXURE I: MEDICAL CERTIFICATE - TO	O BE FILLED BY TREATING DOCTO	DR
1. Name of insured:		
2. Nature of accident/Illness:		
3. Details of injuries/Diagnosis		
4. Are the injuries.		
a) Solely due to accident/Incident:	Yes No	
b) Traceable to any disease/previous injuries:	: Yes No	
c) Was insured under influence of drugs/alcol	hol/intoxicants at the time of accid	ent? Yes No
5. Details of Disablement:		
6. Nature of disablement:		
7. Permanent Total Disablement:	Yes No	
8. Permanent Partial Disablement:	Yes No	
9. Temporary Total Disablement :	Yes No	
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	injured person be confined to bec	I/house as a direct and consequence of the injury
l certify that I have examined the above-name disabled by the accident referred to	ed Insured, the above statements a	are correct and that the injured person is necessarily
Name of Certifying):	Doc	tor Qualification:
Registration No:	Contact Details:	
Date: D D M M Y Y Y Y		Signature & Seal of the Doctor
H. ENCLOSURE CHECKLIST		

#### A. Hospital Daily Cash Benefit

- Certified copy of Hospital discharge Summary with pre & post hospitalization consultation details (if any)
- Certified copy of Diagnostic report confirming diagnosis.
- Certified copy of final hospital bill with detailed break up

#### **B.** Personal Accident – Death

- Certified copy of Death certificate issued by municipal authority
- Certified copy of FIR, MLC Copy, Spot Panchnama.
- Certified copy of Postmortem examination report.

#### C. Personal Accident - Permanent Total Disability

Certified copy of Disability certificate issued by Appropriate Govt/Medical authority

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- Certified copies of hospital treatment records and diagnostic reports
- Certified copy of FIR, MLC Copy, Spot Panchnama.
- Photograph of insured showing disability

#### **BENEFICIARY DETAILS**

- Duly filled and signed Central KYC Registry form (applicable for benefit of Rs 1,00,000 & above)
- Self-attested Copy of PAN card & Aadhar card, photo id & address Proof of the nominee / beneficiary (Pan card / Driving license / Passport / Aadhar Card / Election Card, etc) for address mentioned in claim form (applicable for benefit of Rs 1,00,000 & above)
- Insured bank account / NEFT details: Cancelled cheque or copy of first page of bank passbook showing account holder's name, Account number, IFSC code, Branch name etc.
- Note: The Company reserves the right to seek additional documents (including KYC documents) and information as and when necessary for processing of the claim.

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