SBI General Insurance Company Limited
IRDA Reg. No. 144 dated 15/12/2009 | CIN: U66000MH2009PLC190546

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

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

CRITICAL ILLNESS 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.

Policy No. Claim No.

Period of Insurance From D D M M Y Y Y Y To D D M M Y Y Y Y

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
4. Date of Birth D D M M Y Y Y Y — Gender ☐ Male ☐ Female
5. Address — Plot No/Door No. — Building Name
   Road — Area
   City — Pincode
   State
6. Contact Details — Phone No. — Mobile
   E-mail Id

B. DETAILS OF ILLNESS/ACCIDENT

1. Diagnosis of illness
   ☐ Heart Attack ☐ Cancer ☐ Aorta Surgery ☐ Coronary Artery Bypass Grafting
   ☐ Stroke ☐ Total Blindness ☐ Major Organ Transplant ☐ Paralysis / Paraplegia
   ☐ Myocardial Infarction (First Heart Attack) ☐ Coma ☐ Multiple Sclerosis
   ☐ Kidney Failure (End Stage Renal Failure) ☐ Heart Valve Surgery ☐
2. Signs and symptoms of illness
3. When did you first notice signs and symptoms of the illness? D D M M Y Y Y Y
4. 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. Brief details of Investigation done with the results confirming diagnosis
7. Have you ever had the similar signs / symptoms / illness in past? ☐ Yes ☐ No
   If 'Yes', provide details,
8. Name of the Doctor consulted first
9. Name of the Hospital
10. Contact Details — Phone No. — Mobile
    E-mail Id

Version 1.0, Oct 2014

11. OP No./Hospital No./ Indoor Patient No.

12. Date of first visit to Hospital in this regard D D M M Y Y Y Y Date of last visit D D M M Y Y Y Y

13. Frequency of visits ☐ Weekly ☐ Monthly ☐ Others _____

14. Name of treating Doctor

15. Qualification of treating Doctor Treating Doctors Registration No.

16. Address of the Hospital Plot No/Door No. Building Name

Road Area

City Pincode

State

17. Contact Details Phone No. Mobile

E-mail Id

C. DETAILS OF PREVIOUS CRITICAL ILLNESS CLAIM

1. Have you incurred any claim before under this contract or under all other health contracts? ☐ Yes ☐ No

If Yes, please provide details _____

D. DETAILS OF OTHER INSURANCE/INTEREST

1. Is the Symptoms/Diagnosis/Illness claimed for covered under any other Insurance? ☐ Yes ☐ No

If 'Yes', specify details and attach a copy of the policy

Name of Insurer

Policy Issuance Office Location

Policy No. Sum Insured

Period of Insurance From D D M M Y Y Y Y To D D M M Y Y Y Y

E. PAYEE DETAILS [Payable to Nominee (*All fields are mandatory)]

Bank Name Bank Branch

Bank Account No. IFSC Code

MICR No. PAN No.

Note: It is agreed that the Policyholder/Claimant will intimate in writing to SBI General about any change in bank account details. Please attach a cancelled cheque pertaining to the same account. In case premium is issued from the same bank account through cheque, the cancelled cheque is not required.

F. ENCLOSURES CHECKLIST

☐ Claim Form duly filled & signed ☐ Hospital Summary ☐ Doctor's Certificate ☐ Investigation Reports

☐ Policy Copy ☐ Photo Identity Proof

☐ Any other documents, please specify _____

G. DETAILS OF OTHER INFORMATION

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 Insurer may require in respect of the said claimed event, 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 l claim events covered under the contract shall be forfeited.

I/We, do hereby consent and authorise M/s. SBI General Insurance Co. Ltd., my/our health insurer to collect all medical records, case-sheets, investigation report, lab-reports, test-reports, expert opinions, bills and also all records in relation to the treatment underwent by me/us from the Hospital, Doctors and Other Medical Service Providers.

Place Signature of Claimant/Insured _____

Date: D D M M Y Y Y Y Name of Insured/Claimant _____

MEDICAL CERTIFICATE : To be filed by treating doctor

A. DETAILS OF HOSPITAL

a) Name of the hospital:

b) Name of the treating doctor: SURNAME MIDDLENAME FIRSTNAME

c) Qualification:

d) Registration no with State Code:

f) Phone No:

B. DETAILS OF THE PATIENT ADMITTED

a) Name of the patient: SURNAME MIDDLENAME FIRSTNAME

b) IP Registration No:

c) Gender: Male ☐ Female ☐

d) Age: Years Months

e) Date of birth: DDMMYYYY

f) Date of Admission: DDMMYYYY

g) Time: HH : MM

h) Date of discharge: DDMMYYYY

i) Time: HH : MM

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐

k) Status at the time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐

C. DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a) Diagnosis

i Primary Diagnosis:

ii Additional Diagnosis:

iii Co-morbidities:

iv Co-morbidities:

b) If any, Procedure done detail — Description

I Procedure 1:

ii Procedure 2:

iii Procedure 3:

iv Details of Procedure1

c) Present ailment is a complication of Pre-existing disease ☐ Yes ☐ No (If Yes, specify details)

d) Hospitalization due to Injury: ☐ Yes ☐ No i) If Yes, give cause Self-Inflicted ☐ Road Accident ☐ Any other Accident ☐

I certify that I have examined the above named Insured, the above statements are correct

Name of treating Doctor

Qualifications

Registration No.

Address

Contact Details

Phone No.

E-mail Id

Signature of the Doctor _____

Date DDMMYYYY

Stamp of the Doctor _____

Stamp of the Hospital _____

E. DECLARATION BY THE INSURED

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 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.

Date: DDMMYYYY

Place:

Signature of the insured: