SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

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

MICRO INSURANCE 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. FOR WHICH BENEFIT DO YOU CLAIM? [PLEASE TICK (✓) THE APPROPRIATE BOX]

Benefit	Amount Claimed	Benefit	Amount Claimed
☐ Death		☐ Critical Illness	
☐ PTD		☐ Asset Insurance	
☐ Hospital Cash			

C. DETAILS OF ACCIDENT / ILLNESS

Is claim related to ☐ Accident ☐ Illness

ACCIDENT

1. Date of Accident/Incidence D D M M Y Y Y Y — Time of Loss : A.M. / P.M.
2. Cause of Accident/Incidence
3. Details of Accident/Incidence
4. Accident/Incidence Location Address — Pincode
5. Were there any witness to the Accident/Incidence? ☐ Yes ☐ No
   If 'Yes', provide details, Name of Witness

Version 1.0, Oct' 2013

Address of Witness

Pincode

Contact Details Phone No. Mobile

E-mail Id

6. Is relative of Claimant? Yes No

INFORMATION TO POLICE AUTHORITY

1. Has the loss been reported to Police Authority? Yes No

If 'No', reason for not reporting

First Information Report No. Medico Legal Case (MLC) No.

Report Date D D M M Y Y Y Y

Address of Police Station

Pincode

Contact Details Phone No. Mobile

E-mail Id

2. Was the person moved to hospital immediately after the accident? Yes No

If 'Yes',

3. Name of Hospital

Address of Hospital

Pincode

Contact Details Phone No. Mobile

E-mail Id

4. Date of Admission D D M M Y Y Y Y Date of Discharge D D M M Y Y Y Y

ANNEXURE I: MEDICAL CERTIFICATE - TO BE FILLED BY TREATING DOCTOR

1. Name & Address of the Insured SURNAME MIDDLENAME FIRSTNAME

2. Gender Male Female Date of Birth / Age D D M M Y Y Y Y /

3. Nature of the Accident/Incident and details of injuries sustained

4. Cause of Accident/Incident

5. Is death:
   a) Solely due to Accident/Incident Yes No
   b) Traceable to any disease Yes No
   If 'Yes', give details
   c) Traceable to any previous injury Yes No
   If 'Yes', give details

6. Was insured under influence of drugs / intoxicants / alcohol at the time of accident? Yes No

7. Was the insured suffering from any disease or injury which may have contributed to the accident or likely to aggravate his/her condition? ☐ Yes ☐ No

If 'Yes', give details _____

I certify that I have examined the above named Insured, the above statements are correct and that the injured person is necessarily disabled by the accident referred to

Name of treating Doctor

Qualifications Registration No.

Address

Contact Details Phone No.

E-mail Id

Signature of the Doctor _____ Date D D M M Y Y Y Y

ANNEXURE II: TO BE COMPLETED BY NOMINEE IN THE EVENT OF INSURED'S DEATH

1. Name of Nominee S U R N A M E M I D D L E N A M E F I R S T N A M E
2. Relationship with Insured Date of Birth D D M M Y Y Y Y
3. Address

Pincode

4. Contact Details Phone No. Mobile

E-mail Id

If nominee is minor, kindly provide the Legal Guardian details

5. Name of Guardian S U R N A M E M I D D L E N A M E F I R S T N A M E
6. Relationship with Insured Date of Birth D D M M Y Y Y Y
7. Address

Pincode

8. Contact Details Phone No. Mobile

E-mail Id

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 shall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited.

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.

Place Signature _____

Date D D M M Y Y Y Y Name of Nominee _____

ILLNESS

A. 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 ☐ Any Other, if YES provide details

_____

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

11. Signs and symptoms of illness

12. 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

13. When was the illness first diagnosed/detected? D D M M Y Y Y Y

14. Have you ever had the similar illness in past? ☐ Yes ☐ No

If 'Yes', provide details,

15. Any other past history

16. Brief details of investigation done with the results confirming diagnosis

17. Name of the Doctor consulted first

18. Name of the Hospital

19. Contact Details Phone No. Mobile

E-mail Id

20. 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

21. Date & Time of Admission D D M M Y Y Y Y : A.M. / P.M.

22. Type of Room on the day of admission ☐ ICU ☐ Non-ICU

23. Date & Time of Discharge D D M M Y Y Y Y : A.M. / P.M.

24. No of Days in ICU

No of Days in Non-ICU

25. Name of treating Doctor

26. Qualification of treating Doctor

Treating Doctors Registration No.

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

Road Area

City Pincode

State

28. Contact Details Phone No. Mobile

E-mail Id

D. DETAILS OF PREVIOUS HEALTH CLAIM

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

   If Yes, please provide details _____

   _____

E. 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

F. DETAILS OF OTHER INFORMATION

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

If 'Yes', specify

_____

_____

G. ENCLOSURES CHECKLIST

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

☐ Policy Copy ☐ Photo Identity Proof

☐ Any other documents, please 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

Date: D D M M Y Y Y Y

Signature of Claimant/Insured _____

Name of Insured/Claimant _____