

D. DETAILS OF INSURANCE HISTORY

- a) Currently covered by any other Medclaim / Health Insurance: Yes No
- b) Date of commencement of first Insurance without break: 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:
- Diagnosis:
- e) Previously covered by any other Medclaim/Health insurance : Yes No f) If yes, Company Name:

E. 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. Others (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)

Claim Documents Submitted- Check List:

- | | | |
|---|---|---|
| <input type="checkbox"/> Claim Form Duly signed | <input type="checkbox"/> Copy of the claim intimation, if any | <input type="checkbox"/> Hospital Break-up Bill |
| <input type="checkbox"/> Hospital Bill Payment Receipt | <input type="checkbox"/> Hospital Discharge Summary | <input type="checkbox"/> Pharmacy Bill |
| <input type="checkbox"/> Operation Theatre Notes | <input type="checkbox"/> ECG | <input type="checkbox"/> Doctor's request for investigation |
| <input type="checkbox"/> Investigation Reports
(Including CT/ MRI / USG / HPE) | <input type="checkbox"/> Doctor's Prescriptions | <input type="checkbox"/> Others |

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

Bank Name

Bank Branch

Bank Account No.

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.

Photocopies of cancelled cheque are not considered.

G. 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:

Signature of the Insured

Place:

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

I. Base Cover

Benefit	Amount claimed	Benefit	Amount claimed
<input type="checkbox"/> Accidental Death / Accidental Death (AD) - Common Carrier		<input type="checkbox"/> Permanent partial disability (PPD)	
<input type="checkbox"/> Permanent total disability (PTD)		<input type="checkbox"/> Temporary Total disability (TTD)	

II. Optional Covers

Benefit	Amount claimed
<input type="checkbox"/> Accidental Hospitalization i. Inpatient Hospitalisation (Domestic / Worldwide) - Rs. _____ ii. Day care treatment Rs _____ iii. Radio Cab Rs _____ iv. Road Ambulance Rs. _____ v. Convalescence Rs _____	
<input type="checkbox"/> Accidental Benefit i. OPD Treatment Rs _____ ii. Reconstructive Surgery Rs _____ iii. Coma Benefit Rs _____ iv. Funeral Expenses Rs _____ v. Burns Rs _____ vi. Broken Bones / Fracture Rs _____ vii. Personal Belongings Rs _____	
<input type="checkbox"/> Transportation Benefit i. Compassionate Benefit Rs _____ ii. Transportation of Mortal Remains Rs. _____ iii. Air Ambulance Rs. _____ iv. Transportation of Imported Medicines Rs. _____ v. Catastrophe Evacuation Rs. _____	
<input type="checkbox"/> Dependent Care (Child & Parent) i. Child Education Rs. _____ ii. Marriage Expenses Rs. _____ iii. Loss or Damage to School Bag/ Books/ Spectacles/ Bicycles Rs. _____ iv. Orphan Benefit Rs. _____ v. Parental Care Rs. _____ vi. Widowhood Cover Rs. _____	
<input type="checkbox"/> Loan & Employment Benefit i. Loan Protector Rs. _____ ii. Loss of Income Rs. _____	
<input type="checkbox"/> Modification & Support Benefit i. Modification (Home / Vehicle) Rs. _____ ii. Mobility Extension Rs. _____	
<input type="checkbox"/> Special Benefit Adventure Sports <input type="checkbox"/> More Benefit (Common Carrier) <input type="checkbox"/> Multiple Member Disability <input type="checkbox"/> Enhanced Permanent Total Disablement (PTD). <input type="checkbox"/> S.I Escalation <input type="checkbox"/> Legal Expenses <input type="checkbox"/> Fraud/ Loss of card Liability <input type="checkbox"/> Purchase Of Blood <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> PA Cumulative Bonus <input type="checkbox"/>	

III. Specific Covers

CRITICAL ILLNESS:

Diagnosis of Illness:

- | | | |
|--|---|--|
| 1. Cancer of Specified Severity <input type="checkbox"/> | 2. Myocardial Infraction (First Heart Attack of Specific Severity) <input type="checkbox"/> | 3. Open Chest CABG <input type="checkbox"/> |
| 4. Open Hear Replacement or Repair of Heart valves <input type="checkbox"/> | 5. Coma of Specified Severity <input type="checkbox"/> | 6. Kidney Failure Requiring Regular Dialysis <input type="checkbox"/> |
| 7. Stroke Resulting in Permanent Symptoms <input type="checkbox"/> | 8. Major Organ /Bone Marrow Transplant <input type="checkbox"/> | 9. Permanent Paralysis of Limbs <input type="checkbox"/> |
| 10. Motor Neuron Disease with Permanent Symptoms <input type="checkbox"/> | 11. Multiple Sclerosis with Persisting Symptoms <input type="checkbox"/> | 12. Benign Brain Tumor <input type="checkbox"/> |
| 13. Blindness <input type="checkbox"/> | 14. Deafness <input type="checkbox"/> | 15. End stage of Liver failure <input type="checkbox"/> |
| 16. End stage of Lung failure <input type="checkbox"/> | 17. Loss of Speech <input type="checkbox"/> | 18. Loss of Limbs <input type="checkbox"/> |
| 19. Major Head Trauma <input type="checkbox"/> | 20. Third Degree Burns <input type="checkbox"/> | 21. Primary (Idiopathic) Pulmonary Hypertension <input type="checkbox"/> |
| 22. Alzheimer's Disease <input type="checkbox"/> | 23. Parkinson's Disease <input type="checkbox"/> | 24. Aorta Graft Surgery <input type="checkbox"/> |
| 25. Amputation of Feet Due to Complications from Diabetes <input type="checkbox"/> | 26. Myasthenia Gravis <input type="checkbox"/> | 27. Elephantiasis <input type="checkbox"/> |
| 28. Aplastic Anaemia <input type="checkbox"/> | 29. Loss of Independent Existence (Cover up to Age 74) <input type="checkbox"/> | 30. Dissecting Aortic Aneurysm <input type="checkbox"/> |
| 31. Progressive Scleroderma <input type="checkbox"/> | 32. Chronic Adrenal Insufficiency (Addison's Disease) <input type="checkbox"/> | 33. Other Serious Coronary Artery Disease <input type="checkbox"/> |

- | | | | | | |
|---------------------------------|--------------------------|---|--------------------------|-------------------------------------|--------------------------|
| 34. Severe Rheumatoid Arthritis | <input type="checkbox"/> | 35. Cardiomyopathy | <input type="checkbox"/> | 36. Infective Endocarditis | <input type="checkbox"/> |
| 37. Medullar Cystic Disease | <input type="checkbox"/> | 38. Apallic Syndrome | <input type="checkbox"/> | 39. Creutzfeldt-Jacob Disease (CJD) | <input type="checkbox"/> |
| 40. Ebola | <input type="checkbox"/> | 41. Pneumonectomy | <input type="checkbox"/> | 42. Brain Surgery | <input type="checkbox"/> |
| 43. Severe Ulcerative Colitis | <input type="checkbox"/> | 44. Chronic Relapsing Pancreatitis | <input type="checkbox"/> | 45. Progressive Supranuclear Palsy | <input type="checkbox"/> |
| 46. Terminal Illness | <input type="checkbox"/> | 47. Fulminant Hepatitis | <input type="checkbox"/> | 48. Crohn's Disease | <input type="checkbox"/> |
| 49. Bacterial Meningitis | <input type="checkbox"/> | 50. Loss of One Limb and One Eye | <input type="checkbox"/> | 51. Necrotising Fasciitis | <input type="checkbox"/> |
| 52. Muscular Dystrophy | <input type="checkbox"/> | 53. Hemiplegia | <input type="checkbox"/> | 54. Poliomyelitis | <input type="checkbox"/> |
| 55. Tuberculosis Meningitis | <input type="checkbox"/> | 56. Encephalitis | <input type="checkbox"/> | 57. Myelofibrosis | <input type="checkbox"/> |
| 58. Pheochromocytoma | <input type="checkbox"/> | 59. Systemic Lupus Erythematosus with Lupus Nephritis | <input type="checkbox"/> | 60. Eisenmenger's Syndrome | <input type="checkbox"/> |

Name of the investigation with the results confirming diagnosis: _____

Date of disease first detected:

Have you ever had the similar condition in past Yes No. If 'Yes', provide details, _____

Date of first visit to Hospital in this regard:

OP Number/Hospital No./Indoor Patient No.: _____

Date of last visit: Frequency of visits (Weekly/Monthly/Other): _____

Name of the Hospital

Phone No. Mobile

E-mail Id

Name of Treating Doctor:

Qualification of treating Doctor: Treating Doctors Registration No.:

Address

Street

City District

State Pin Code

Phone Number Phone No. Mobile

E-mail Id

Progress: Death Recovered Improved Unimproved Retrogressed

In case of death, date of death:

2. Vector Borne

Dengue Rs Malaria Rs Chikungunya Rs Kala Azar Rs Zika Virus Rs
 Plague Rs Japanese encephalitis Rs Filariasis Rs

3. Hospicash Rs.....

4. Assistance Services Rs.....

Nursing at Home ICU at Home Physiotherapy Domestic Help
 Trauma Counselling Financial Guidance

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

Annexure III: DETAILS OF FAMILY MEMBER REQUIRED FOR DEPENDANT BENEFIT IN CASE OF CRITICAL ILLNESS CLAIM (INCLUDING NEFT DETAILS)

Name of Dependent Claimant:

Relationship with insured:

Dependant's Bank Account details: Bank Name: Branch:

Savings Account No IFSC Code:

MICR Code: (Please attach copy of first page of bank passbook/letter from bank confirming account details with name of account holder, IFSC & MICR details) or Attach a cancelled cheque. (Photocopies of cancelled cheque are not considered)

Annexure IV: BANK CERTIFICATE FORM

CERTIFICATE OF BANK

This is to certify that Mr. / Mrs. _____ is a holder of Loan account No. _____.

The Loan Account was held by the aforesaid person. The original Loan amount Rs. _____ was disbursed on _____.

The total outstanding principle loan amount including interest thereof is Rs. _____ as on date of loss i.e. _____ of the above account holder. The Details of his/her loan account are as below.

Loan Account Number: _____ Loan Type: _____ Loan Tenure: _____

Last EMI due date: _____ Monthly EMI _____

Current loan status if closed date of closure: _____ Loan outstanding amount: _____

Principle outstanding as on date of loss: _____ Interest amount outstanding as on date of loss: _____

Overdue charges /penalties (if any): _____

AUTHORISED SIGNATORY STATE BANK OF INDIA

NAME OF THE SIGNATORY : _____ SIGN AND STAMP : _____

BRANCH : _____ BRANCH CODE : _____

PLACE : _____ DATE : _____

DETAILS OF ACCOUNT TO WHICH CLAIM AMOUNT SHOULD BE REMITTED
(To be filled & certified by bank only)

Copy of bank passbook/cheque to be attached if claim to be paid in favour of insured or legal heirs

Name of the Loan Account/Beneficiary Bank Account:

Bank Name:

Branch and Address:

Street

City District

State Pin Code

Loan A/C No: IFSC Code:

MICR Code: Pan No:

E-mail ID (Branch e-mail):

I, hereby authorize SBI General Insurance Co. Ltd. to make the payment of claim in respect of Account Nos. _____

_____ to above referred

Bank Account and I confirm the Bank account details furnished as above are correct.

Name of Branch Manager: _____

Signature: _____

Date: _____

Place: _____

ENCLOSURES CHECKLIST

Please attach following documents and tick appropriate box. (Please attach documents as per benefit claimed and tick appropriate box)

1. Accidental Death/Accidental Death-Common Carrier

- Claim Form duly filled & signed
- Claim Intimation
- Police Copy
- Copy of FIR (First Information Report) / Spot Panchnama / Inquest Panchnama
- Death Certificate
- Death Summary
- Post Mortem Report
- Original Legal Heir Certificate (in case nomination has not been filed by deceased)

2. Permanent Total Disablement / Permanent Partial Disablement / Temporary Total Disablement:

- Claim Form duly filled & signed
- Claim Intimation
- Police Copy
- Copy of FIR (First Information Report) / Spot Panchnama / Inquest Panchnama
- Photograph of the injured with reflecting disablement
- Disability Certificate from appropriate Government Authority
- Medical Certificate from treating Doctor
- Leave Certificate from the Employer
- Investigation Reports
- Treatment Papers

3. Accidental Medical Expenses – As Inpatient / Outpatient:

- Same as the documents of List – 2, plus Medical Certificate from treating Doctor
- Investigation report
- Treatment papers

4. Child Education Support:

- All documents of List – 1 or List - 2, plus
- Study Certificate from the school of the dependent child mentioning the parent's name

5. Loan Protector

- All documents of Accidental death & Permanent total Permanent Total Disablement / Permanent Partial Disablement / Temporary Total Disablement
- Loan Approval Letter
- Loan due statement
- Loan EMI Paid Proof

6. Funeral Expenses:

- All Documents of List – 1, plus
- Original Legal Heir Certificate (in case nomination has not been filed by deceased)
- Original Bills and payment receipt of funeral expenses
- Original Bills and payment receipt of repatriation expenses

7. Modification (Home/Vehicle)

- Certification from Medical Practitioner necessitating the Modification.
- Original Invoices of actual expenses incurred for the Modifications.

8. Transportation of Mortal Remains

- Original Invoices of expenses incurred for Carriage of Dead Body/repatriation of mortal remains.

9. Road Ambulance Cover

- All documents of List – 1 or List - 2, plus
- Original Bills and payment receipt for Ambulance use
- Treating Doctor's consultation indicating need of Ambulance

10. Broken Bones:

- Same as the documents of List – 2, plus
- X ray Confirmation Report
- X ray Film

11. Loss of Books/Spectacles/Damage to Bicycles of School Children:

- Same as the documents of List – 2, plus
- Original Bills and payment receipt Loss of Books
- Original Bills and payment receipt Spectacles
- Original Bills and payment receipt of repair of Damage to Bicycles of School Children

12. Purchase of Blood:

- All documents of List – 1 or List - 2, plus
- Bills and payment receipt – Purchase of blood
- Blood bank label for utilized blood
- Prescription of the doctor mentioning the indication of need of blood transfusion

13. Vector Borne Diseases

- Medical Records / Reports
- Investigation Test Reports
- Medical Practitioner's Certificate confirming the Illness /Treatment advise / Medical Reference
- Consultation Papers
- Copy of Hospital Summary
- Death Certificate (If applicable)

14. Hospi Cash

- Hospital Discharge Summary

15. Trauma counselling

- Documents mentioned under 1. Accidental death and 2 Permanent Total Disablement /Permanent Partial Disablement/Temporary Total Disablement
- Original Invoice of Expenses Incurred for Counselling.
- Medical Practitioner's letter advising Counselling
- Treatment plan for Counselling from Specialist.

16. ICU at home

- Attending Physician Certificate mentioning the need for Home (Domiciliary Hospitalization)
- Original Pharmacy Bills
- Consultation Papers
- Original Investigation bills and Reports
- Original Invoices in respect of payment made to the treating Medical Practitioner.

17. Burns

- Certificate from Treating Medical Practitioner with extent of Burns Injury/Cause of Burns.
- Treatment Details
- Medico Legal Certificate copy / First Information Report Copy (If applicable)
- Discharge Summary (if Hospitalized)

18. Compassionate Visit

- Letter from Medical Practitioner advising presence of Immediate Family Member
- Original travel tickets / bills and receipts mentioning the actual expenses of the travel with the date of booking & date of travel
- Age Proof of the Person who has visited the Insured.

19. Marriage Expense:-

- Proof of Relationship with the Insured Person
- Photo Identity Proof of Child
- Age Proof of the Dependent Child

20. Critical Illness

- Medical Records / Reports
- Investigation Test Reports
- Medical Practitioner's Certificate confirming the Illness /Treatment advise / Medical Reference

21. Emergency Evacuation (Air Ambulance):-

- Original bills and receipts paid for the transportation from Registered Ambulance Service Provider
- Letter from Medical Practitioner indicating emergency need for such transportation and fitness for transportation.

22. Coma Benefit:-

- Certificate from the Treating Medical Practitioner certifying the cause and severity of Coma.
- All relevant medical summary leading to Coma.

23. Loss of Income

Attested copy of FIR. (If required)

- All Investigation reports confirming the disability
- For Employed persons: Certificate from HR with details of medical leave availed during the period of Injury
- Certificate from the treating doctor mentioning the extent of Injury along with the period of disability
- Certificate from Treating doctor with date of full recovery & resuming of duties
- Certificate from the Employer confirming the termination, dismissal, temporary suspension or retrenchment from employment of the Insured furnishing the date of termination, dismissal, temporary suspension or retrenchment from employment of the Insured with the reasons

for the same. In case of temporary suspension, the period of suspension should also be mentioned in such certificate.

- Appointment Letter
- Latest Copy of Salary Revision, if any.
- Last 3 Months Salary Slip
- Form 16
- Contact details of Employer-Phone No. Mobile No., E-mail ID, Contact person in HR/Admin/Personnel dept.
- Appointment Letter Employer if Re employed
- Age proof of Insured: Aadhar Card, Election ID Card / PAN Card/ School Leaving
- Form 26AS which shows tax deducted at source
- Income tax return for relevant financial year
- Self-declaration
- Any other document as required by Us to investigate the Claim or Our obligation to make payment for it, including documents related to proof that the Insured has not found any job or has not started working again in Family business or started his / her own venture.

24. Radio cab:-

- Original Radio Cab bills and payment receipts paid for the transportation
- Letter from Medical Practitioner indicating emergency need for such transportation.