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

SBI GENERAL HEALTH ALPHA

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 the Insured Person/Claimant or anyone acting on behalf of the Insured Person, then the benefits under this policy shall be void and all benefits payable 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

DETAILS OF INSURED/CLAIMANT

1. Name of the Claimant — SURNAME | MIDDLENAME | FIRSTNAME
2. Name of the Insured — SURNAME | MIDDLENAME | FIRSTNAME
3. Relationship with Insured | Designation (if applicable)
4. Date of Birth of Insured D D M M Y Y Y Y | Gender ☐ Male ☐ Female | Employee No.
5. Address — Plot No/Door No. | Building Name; Road | Area; City | District; State | Pincode
6. Contact Details — Phone No. | Mobile; E-mail Id

DETAILS OF OTHER INSURANCE

1. Is the Accident/Incidence covered under any other Insurance? ☐ Yes ☐ No

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

Name of Insurer | Policy No.

Policy Issuance Office Location | Sum Insured (Rs.)

Period of insurance From D D M M Y Y Y Y To D D M M Y Y Y Y

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. Photocopies of canceled cheque is not considered.

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.

Place

Date D D M M Y Y Y Y

Signature of the Insured

Version 1.0, Jan 2026

ANNEXURE I (Hospitalisation Cover): Details of Hospitalisation.

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: D D M M Y Y Y Y f) Time: H H : M M

g) Date of Discharge: D D M M Y Y Y Y h) 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:

ANNEXURE I Hospitalization Cover): 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 (Road / Air) 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)

c) Special Covers (with Hospitalization Cover only)

i. Hospital Daily Cash: Rs. ii. Convalescence: Rs.

iii. Others: Rs. iv. Companion Cover Rs.

v. Adventure Sports Rs. vi Gym & Sports Injury Rs.

vii Reconstructive Surgery Rs. viii Prosthetics Rs.

ix Gender Reassignment Rs. x Vision Correction Rs.

d) Essential Covers (with Hospitalization Cover only)

i. Radio Cab Rs. ii. Organ Donor Rs.

iii. Home Health Care Rs. iv. Others: Rs.

v. Modern Treatments Rs.

e) Maternity & Child care cover (with Hospitalisation Cover Only)

i. Maternity Expenses Rs. ii. Newborn Baby Cover Rs.

iii. Child Vaccination Cover Rs. iv. Assisted Reproduction Treatment Rs.

f. OPD Covers Rs. g. Global Cover Rs Rs.

Claim Documents Submitted- Check List:

- ☐ Claim Form Duly signed
- ☐ Copy of the claim intimation, if any
- ☐ 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

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1.		D D M M Y Y		Hospital Main Bill	
2.		D D M M Y Y		Pre-hospitalization Bills: Nos	
3.		D D M M Y Y		Post-hospitalization Bills: Nos	
4.		D D M M Y Y		Pharmacy Bills	
5.		D D M M Y Y			
6.		D D M M Y Y			
7.		D D M M Y Y			
8.		D D M M Y Y			
9.		D D M M Y Y			
10.		D D M M Y Y			

ANNEXURE II (Personal Accident Cover): Details of the Accident and Incidence

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

City District

State Pincode

5. Were there any witness to the Accident/Incidence? ☐ Yes ☐ No

If 'Yes', provide details,

Name of Witness

Address of Witness Plot No/Door No. Building Name

Road Area

City District

State Pincode

Contact Details Phone No. Mobile

E-mail Id

6. Is Witness relative of Claimant? ☐ Yes ☐ No

ANNEXURE II (Personal Accident Cover): 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 Plot No/Door No. Building Name

Road Area

City District

State Pincode

Contact Details Phone No. Mobile

E-mail Id

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

If 'Yes',

3. Name of Hospital

Address of Hospital — Plot No/Door No. — Building Name

Road — Area

City — District

State — 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 II (Personal Accident Cover): For Which benefit do you claim? [PLEASE TICK (✓) THE APPROPRIATE BOX]

Benefit	Amount claimed	Benefit	Amount claimed
☐ Accidental Death		☐ Home Modification Benefit	
☐ Permanent Total Disability (PTD)		☐ Child Education Benefit	
☐ Permanent Partial Disability (PPD)		☐ Loan Protector Benefit	
☐ Temporary Total Disability (TTD)			

ANNEXURE II (Personal Accident Cover) : To be completed by Nominee in the event of Insured's Death

1. Name of Nominee (SURNAME MIDDLE NAME FIRST NAME)

2. Relationship with Insured — Date of Birth (D D M M Y Y Y Y) Sex ☐ M ☐ F

3. Address — Plot No/Door No. — Building Name

Road — Area

City — District

State — Pincode

4. Contact Details — Phone No. — Mobile

E-mail ID

If nominee is minor, kindly provide the Legal Guardian details

5. Name of Guardian (SURNAME MIDDLE NAME FIRST NAME)

6. Relationship with Insured — Date of Birth (D D M M Y Y Y Y)

7. Address — Plot No/Door No. — Building Name

Road — Area

City — District

State — Pincode

8. Contact Details — Phone No. — Mobile

E-mail Id

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.

Place Signature _____

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

ANNEXURE II (Personal Accident Cover): To be filled by treating Doctor

1. Name & Address of the Insured — SURNAME | MIDDLE NAME | FIRST NAME

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. Are the injuries:
   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 / alcohol / intoxicants at the time of accident? ☐ Yes ☐ No

7. Is the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his/her condition or delay improvement? ☐ Yes ☐ No

   If 'Yes', give details _____

   Details of Disablement _____

   Nature of Disablement
   a) Permanent Total Disablement ☐ Yes ☐ No
   b) Permanent Partial Disablement ☐ Yes ☐ No
   c) Temporary Total Disablement ☐ Yes ☐ No

   Details of Disablement _____

   Details of treatment given _____

8. According to you, how long should the injured person be confined to bed/house as the direct and sole consequence of the injury sustained? From D D M M Y Y Y Y To D D M M Y Y Y Y

9. During this period will the injured person be able to attend to his/her normal duties? ☐ Yes ☐ No

   If 'Yes', from D D M M Y Y Y Y

   If 'No', please state probable date of his / her being able to attend to his normal duties D D M M Y Y Y Y

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 D D M M Y Y Y Y

Stamp of the Doctor _____ Stamp of the Hospital _____

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ANNEXURE III (Benefit based Covers):

- ☐ Cancer of specific severity
- ☐ Myocardial Infarction (First Heart Attack of Specific Severity)
- ☐ Open Chest CABG
- ☐ Open Heart Replacement or Repair of Heart Valves
- ☐ Coma of Specified Severity
- ☐ Kidney Failure Requiring Regular Dialysis
- ☐ Stroke Resulting in Permanent Symptoms
- ☐ Major Organ/ Bone Marrow Transplant
- ☐ Permanent Paralysis of Limbs
- ☐ Motor Neurone Disease with Permanent Symptoms

Name of the investigation with the results confirming diagnosis: _____

Date of disease first detected: D D M M Y Y Y Y

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

Date of first visit to Hospital in this regard: D D M M Y Y Y Y

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

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

Hospital Daily cash Rs. ☐☐☐☐☐☐☐

ENCLOSURE II Checklist for Personal Accident Covers

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

1. **Accidental Death:**
   - ☐ 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. **Education Benefit:**
   - ☐ All documents of List – 1 or List - 2, plus
   - ☐ Study Certificate from the school of the dependent child mentioning the parent's name

4. **Home Modification Cover/Adaptation Allowance:**
   - ☐ All documents of List - 2, plus
   - ☐ Original Bills and payment receipt of Adaptation done
   - ☐ Prescription of the doctor mentioning the indication for Adaption

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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