CLAIM FORM

KUTUMB SWASTHYA BIMA POLICY - Retail

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

(To be filled in block letters)

A. DETAILS OF PRIMARY INSURED

Policy No: Claim 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 Y

A. DETAILS OF INSURED/CLAIMANT

1. Name of Proposer/Claimant/ Primary Insured:
2. Name of Guardian in case nominee is minor:
3. Name of Insured (for whom claim is registered):
4. Relationship to Primary insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐

(Please Specify)____________________

Address:

Pincode:

Contact Details: Phone No. Mobile:

E-mail Id: Date of Birth: D D M M Y Y Y Y

Gender: Male ☐ Female ☐ Age: years months

Name & address of policy owner (Bank/Group):

Pincode:

Phone No.: Mobile:

E-mail Id: Date of Birth: D D M M Y Y Y Y

Gender: Male ☐ Female ☐ Age: years months

B. WHAT BENEFIT DO YOU CLAIM?

Personal Accident: Death ☐ Disability ☐

Hospital Daily cash: For injury ☐ For Illness ☐

C. Fill details For PERSONAL ACCIDENT CLAIM

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:
4. Accident location:
5. Has the loss been reported to Police: Yes ☐ No ☐

If yes, Name & address of police station

If No, reason for not reporting

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

(If Yes, Provide hospital treatment records)

7. In case of Permanent Total Disability Mention nature of disability

a. Nature of disability

b. Is the claimed disability certified by Competent Govt Authority: Yes ☐ No ☐

Disclaimer: SBI General Insurance Company Limited I Corporate & Registered Office: 'Natraj', 301, Junction of Western Express Highway & Andheri - Kurla Road, Andheri (East), Mumbai - 400 069. | For more details on the risk factor, terms, and conditions, please refer to the Sales Brochure and Policy Wordings carefully before concluding a sale. I For SBI General Insurance Company Limited IRDAI Reg. No. 144 dated 15/12/2009 | CIN: U66000MH2009PLC190546 | SBI Logo displayed belongs to State Bank of India and used by SBI General Insurance Co. Ltd. under license | UIN:

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D. Fill details for HOSPITAL DAILY CASH BENEFIT CLAIM

1. Diagnosis of illness/injury:
2. Date of 1st diagnosis: D D M M Y Y Y Y
3. Name of Treating Doctor:
4. Name & address of hospital:

Pincode:

5. Date of admission: D D M 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 & treatment:________________________________

Name & contact detail of Treating doctor________________________________

E. PAYEE DETAILS (*All fields are mandatory / Please enclose cancelled cheque copy)

1. Payable To: Policy Holder ☐ Primary Insured ☐ Nominee ☐

Name of Guardian in case of minor nominee:

3. Proof of Bank Account Details provided: Cancelled Cheque ☐ Passbook Copy ☐
4. Bank Name: Bank Branch:

Bank Account No.: IFSC Code:

MICR No.: 5. PAN No.:

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

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 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: D D M M Y Y Y Y

Signature of Claimant:

Date:

Name of Claimant:________________________________

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

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/alcohol/intoxicants at the time of accident? 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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10. According to you, how long should the injured person be confined to bed/house as a direct and consequence of the injury sustained: (please mentioned dates):____________________

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 Certifying Doctor:____________________ 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
- 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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