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

COMPREHENSIVE PROTECTION POLICY
CLAIM FORM

TO BE FILLED IN BY THE INSURED
The issue of this Form is not to be taken as an admission of liability

(To be filled in block letters)

DETAILS OF PRIMARY INSURED:

a) Policy No:

b) SI. No/ Certificate No: c) Company/ TPA ID No:

d) Name: SURNAME MIDDLE NAME FIRST NAME

e) Address :

City: State:

Pin Code: Phone No:

Email ID:

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim / Health Insurance: Yes No

b) Date of commencement of first Insurance without break: D D M M Y Y Y Y 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: D D M M Y Y Y Y

Diagnosis:

e) Previously covered by any other Mediclaim/Health insurance : Yes No f) If yes, Company Name:

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name: SURNAME MIDDLE NAME FIRST NAME

b) Gender: Male Female c) Age: years Y Y months M M d) Date of Birth: D D M M Y Y Y Y

e) Relationship to Primary insured: Self Spouse Child Father Mother Other (Please Specify)

f) Occupation: Service Self Employed Homemaker Student Retired Other (Please Specify)

g) Address (if different from above):

City: State:

Pin Code: Phone No:

E-mail ID:

DETAILS OF OTHER INSURANCE/INTEREST

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

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

Benefit	Amount claimed	Benefit	Amount claimed
☐ Accidental Death		☐ Education Benefit	
☐ Permanent Total Disability (PTD)		☐ Payment Protection	
☐ Permanent Partial Disability		☐ Broken Bones	
☐ Temporary Total Disability (TTD)		☐ Hospital Daily Cash, Convalescence/ EMI Protect Benefit	
		TOTAL AMOUNT CLAIMED	

DETAILS OF HOSPITALIZATION

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:

DETAILS OF CLAIM

Details of Lump sum/cash benefit claimed:

1. Hospital Daily cash	₹	5. Payment Protection	₹
2. Convalescence / EMI protect	₹	6. Family Protection	₹
3. Major Surgical Procedure	₹	7. Education Benefit	₹
4. Infectious Diseases	₹	8. Others	₹
		Total	₹

Claim document submitted -checklist

- ☐ 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									

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

Bank Name

Bank Branch

Bank Account No.

IFSC Code

MICR No.

PAN No.

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: D D M M Y Y Y Y

Signature of the Insured

Place:

DETAILS OF ILLNESS/ACCIDENT/INCIDENCE

Accidental Death/ Permanent Total Disablement (PTD)/ Permanent Partial Disablement (PPD)/ Temporary Total Disablement (TTD) /Broken Bones /Burns/ Mobility Extension

Date of Accident / Incidence D D M M Y Y Y Y

Time of Accident / Incidence A.M. P.M.

Details of Accident/ Incidence _____

_____

Accident/ Incidence Location Address

Street

City District

State Pin Code

Phone Number of Claimant

Phone No. Mobile

E-mail Id

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

Name of Person

Address

Street

City District

State Pin Code

Phone Number of Claimant

Phone No. Mobile

E-mail Id

A. Accidental Death D D M M Y Y Y Y B. Date of Death D D M M Y Y Y Y C. Place of Death

D. Name of hospital where insured was admitted immediately post accident (if applicable):

Permanent Total Disability

Nature of Disability

Name & Address of Certifying authority:

Street

City District

State Pin Code

Name & Address of Hospital where Insured was treated

Street

City District

State Pin Code

ANNEXURE II: MEDICAL CERTIFICATE - 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 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

Stamp of the Doctor _____ Stamp of the Hospital _____

DETAILS OF ILLNESS/ACCIDENT/INCIDENCE

SECTION I – CRITICAL ILLNESS

1. Signs and symptoms of illness _____

_____

2. Diagnosis of illness

- ☐ Cancer
- ☐ Coma
- ☐ Aorta Surgery
- ☐ Coronary Artery Bypass Grafting
- ☐ Heart Valve Replacement
- ☐ Stroke
- ☐ Major Organ Transplant
- ☐ Myocardial Infarction (First Heart Attack)
- ☐ Aorta Graft Surgery
- ☐ Multiple Sclerosis
- ☐ Kidney Failure (End Stage Renal Failure)
- ☐ Third Degree Burns
- ☐ Total Blindness

3. Name of the investigation with the results confirming diagnosis

4. Date of disease first detected D D M M Y Y Y Y

5. Have you ever had the similar conditions in past? ☐ Yes ☐ No

If 'Yes', provide details, _____

_____

6. 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

7. Frequency of visits ☐ Weekly ☐ Monthly ☐ Other _____

8. Name of the Hospital

9. Contact Details Phone No. Mobile

E-mail Id

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

Road Area

City Pincode

State

11. Name of Treating Doctor

12. Qualification of Treating Doctor Treating Doctors Registration No.

13. Contact Details Phone No. Mobile

E-mail Id

14. OP No. / Hospital No. / Indoor Patient No.

15. Progress ☐ Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed

LOSS OF SALARY/EMPLOYMENT

1. Name of Bank / Financial Institution

2. Address Plot No/Door No. Building Name

Road Area

City Pincode

State

3. Contact Details Phone No. Mobile

E-mail Id

4. Loan Account No. Loan Type

5. Amount of Loan Rs. EMI Rs.

6. Date of Loan Disbursement D D M M Y Y Y Y Tenure of Loan Months

7. Date of last EMI paid D D M M Y Y Y Y Amount of last EMI paid

8. Name of Employer

9. Address Plot No/Door No. Building Name
   Road Area
   City Pincode
   State

10. Contact Details Phone No. Mobile
    E-mail Id

11. Date of Appointment/Joining D D M M Y Y Y Y Designation

12. Date of Termination / Suspension/ Retrenchment D D M M Y Y Y Y

13. Reasons for Termination

14. Date of Reinstatement (in case of Suspension) D D M M Y Y Y Y

INFORMATION TO AUTHORITY

1. Has the loss been reported to an Authority Yes No

   If 'No', reason for not reporting

   If 'Yes', provide details Police Other

2. Name of Authority

3. First Information Report/ MLC No. Report Date D D M M Y Y Y Y

4. Name of Person

5. Address Plot No/Door No. Building Name
   Road Area
   City Pincode
   State

6. Contact Details Phone No. Mobile
   E-mail Id

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

   If 'Yes',

   Name of Hospital

   Address of Hospital Plot No/Door No. Building Name
   Road Area
   City Pincode
   State

   Contact Details Phone No. Mobile
   E-mail Id

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

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 Company may require in respect of the said accident, 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 loss/accident shall be forfeited.

Place

Date: D D M M Y Y Y Y

Signature of Insured/Claimant

Name of Insured/Claimant

DETAILS OF PREVIOUS CLAIM

1. Have you incurred any claim before? ☐ Yes ☐ No

If Yes, please provide details

Name of Insurer

Policy issuance office location

Policy No. Sum Insured Rs.

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

DETAILS OF OTHER INSURANCE/INTEREST

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 issuance office location

Policy No. Sum Insured Rs.

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

ENCLOSURES CHECKLIST

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. **Hospital Daily Cash, Convalescence/ EMI Protect benefit**
   - ☐ Claim Form duly filled & signed
   - ☐ Claim Intimation
   - ☐ Policy Copy
   - ☐ Copy of FIR (First Information Report) / Spot Panchnama / Inquest Panchnama
   - ☐ Discharge summary

4. **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

5. **Payment Protection**
   - ☐ All documents of List – 1 or List - 2, plus
   - ☐ Loan Approval Letter
   - ☐ Loan Due Statement
   - ☐ Last EMI paid proof

6. **Broken Bones:**
   - ☐ Same as the documents of List – 2, plus
   - ☐ X ray Confirmation Report
   - ☐ X ray Film

Note: The Company reserves the right to seek additional documents (including KYC documents) and information as and when necessary for processing of the claim.