HEALTH INSURANCE

Aditya Birla Health Insurance Co. Limited

ADITYA BIRLA CAPITAL

PROTECTING INVESTING FINANCING ADVISING

Claim Form Part A - Critical Illness & Hospital Cash

Section A - Details of the Proposer:

a) Policy No.:

b) SI No./Certificate No.

c) Name:

d) Address:

City: State:

Pin Code:

e) Phone No:

f) Email ID:

Section B - Details of Insurance History:

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

b) If yes,

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

ii) Policy No.

iii) Sum Insured (Rs.)

c) Have you been hospitalized in the last four years since inception of the contract? Yes No

I) Date D D M M Y Y Y Y

ii) Diagnosis:

d) Were you previously covered by any other Mediclaim /Health insurance: Yes No

e) If yes, Company Name

Section C - Details of Insured Person Hospitalized:

a) Name:

b) Gender: Male Female c)Age: years months

d) Date of Birth: D D M M Y Y Y Y

e) Relationship to Proposer: 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:

h) Phone No:

i) E-mail ID:

Section D - 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: D D M M Y Y Y Y Date when the Disease was first detected: D D M M Y Y Y Y

Date of Delivery: D D M M Y Y Y Y

e) Date and time of Admission: Date D D M M Y Y Y Y Time

f) Date and time of Discharge: Date D D M M Y Y Y Y Time

g) If Injury give cause ☐ Self inflicted ☐ Road Traffic Accident

☐ Substance Abuse / Alcohol Consumption

h) If Medico legal: ☐ Yes ☐ No i) Reported to police: ☐ Yes ☐ No

j) MLC Report & Police FIR attached: ☐ Yes ☐ No

k) System of Medicine:

Section E - Details of Claim:

a. Details of the amount claimed:

i. Hospital Daily Cash: Rs. _____

ii. Critical Illness Benefit: Rs. _____

Kindly tick the critical illness which the Insured Person is diagnosed with: -

S.No	Critical Illness	S.No	Critical Illness
	Section A		
1	Cancer of specific severity	33	Poliomyelitis
2	Myocardial Infarction (First Heart Attack – of Specific Severity)	34	Systemic Lupus Erythematous
3	Open Chest CABG	35	Brain Surgery
4	Open Heart Replacement or Repair of Heart Valves	36	Severe Rheumatoid Arthritis
5	Kidney Failure Requiring Regular Dialysis	37	Creutzfeldt-Jakob disease
6	Stroke Resulting in Permanent Symptoms	38	Hemiplegia
7	Major Organ / Bone Marrow Transplant	39	Tuberculosis Meningitis
8	Permanent Paralysis of Limbs	40	Dissecting Aortic aneurysm
9	Multiple Sclerosis with Persisting Symptoms	41	Progressive Supranuclear Palsy – resulting in permanent symptoms
10	Coma of Specified Severity	42	Myasthenia Gravis
11	Motor Neuron Disease with Permanent Symptoms	43	Infective Endocarditis
12	Third Degree Burns	44	Pheochromocytoma
13	Deafness	45	Eisenmenger's Syndrome
14	Loss of Speech	46	Chronic Adrenal Insufficiency
15	Aplastic Anaemia	47	Progressive Scleroderma
16	End Stage Liver Failure	48	Elephantiasis
17	End Stage Lung Failure	49	Cardiomyopathy – of specified severity

18	Bacterial Meningitis	50	Myelofibrosis
19	Fulminant Hepatitis	51	Angioplasty
20	Muscular Dystrophy	52	Pericardectomy
21	Parkinson's disease	53	Ovarian tumour of borderline malignancy/low malignant potential – with surgical removal of an ovary
22	Benign Brain Tumor	54	Keyhole Coronary Surgery
23	Alzheimer's Disease	55	Severe Crohn's disease – surgically treated
24	Aorta Graft Surgery	56	Cardiac Defibrillator insertion or Cardiac Pacemaker insertion
25	Loss of Limbs	57	Carcinoma in-situ of the cervix uteri – requiring treatment with hysterectomy
26	Blindness	58	Carcinoma in-situ of the urinary bladder
27	Primary (Idiopathic) Pulmonary Hypertension	59	Carotid Artery Surgery
28	Apallic Syndrome or Persistent Vegetative State (PVS)	60	Ductal or Lobular carcinoma in-situ of the breast – with specified treatment
29	Encephalitis	61	Small Bowel Transplant
30	Chronic Relapsing Pancreatitis	62	Severe ulcerative colitis – with operation to remove the entire large bowel
31	Major Head Trauma	63	Testicular carcinoma in situ – requiring surgery to remove at least one testicle
32	Medullary Cystic Disease	64	Surgical removal of an eyeball

For Cancer Secure Cover:

Sr No	Event
1	Early Stage Cancer
2	Major Stage Cancer
3	Advanced Stage Cancer

b. Common Claim Documents to be submitted - Critical Illness & Hospital Cash (Original / Self Attested / Document collected via Electronic Medium / Any other mode as suggested by company from time to time):

i. Claim Form duly completed and signed as prescribed by Us
ii. Photo ID and Age proof of insured person / Nominee (if insured person is not alive)
iii. Copy of the claim intimation, if any
iv. Final Hospital Bill
v. Hospital Discharge Summary / Day care summary / Transfer summary
vi. Operation Theatre Notes
vii. Investigation Reports (Including CT scan/ MRI /USG / Histopathology or Biopsy report)
viii. Doctor's Prescriptions
ix. Cancelled cheque for NEFT
x. Others

1. **Check list of documents for submission of Critical Illness claims (Original / Self Attested / Document collected via Electronic Medium / Any other mode as suggested by company from time to time):**

The Insured Person at their own expenses shall submit the following documents within 90 (ninety) days of the earliest of the date of first diagnosis of the Critical Illness/ date of Surgical Procedure or date of occurrence of the medical event, as the case may be:

a) Medical certificate confirming the diagnosis of Critical Illness
b) Certificate from attending Medical Practitioner confirming that the claim does not relate to any Pre-existing Disease or Injury or any Illness or Injury which was diagnosed within the first 90 days of the Inception Date.
c) Discharge certificate/ card from the Hospital, if any
d) Investigation test reports confirming the diagnosis,
e) First consultation letter and subsequent prescriptions
f) Indoor case papers if applicable
g) Specific documents listed under the respective Critical Illness
h) In the cases where Critical Illness arises due to an accident, FIR copy or medico legal certificate will be required wherever conducted.

We may call for any additional documents/information as required based on the circumstances of the claim.

2. **Check list of documents for submission of Hospital Cash claims (Self Attested / Document collected via Electronic Medium / Any other mode as suggested by company from time to time):**

The following documents as per the benefit being sought must be provided to Us within 30 of the occurrence of the event giving rise to a claim under the Policy:

a) Discharge card / day care summary / transfer summary
b) Final Hospital Bill
c) Previous consultation papers indicating history and treatment details for current ailment.
d) Diagnostic test reports (including imaging and laboratory) along with the Medical prescription & copy of invoice / bill and receipt from the diagnostic centre.
e) MLC / FIR copy – in Accidental cases only
f) Death summary & death certificate (in death claims only)

If These details are not provided in full or are insufficient for Us to consider the request, then we will request additional information or documentation in respect of that request.

Section F - Details of Proposer's Bank Account:

a) PAN No:
b) Bank Name and Branch:
c) Bank Account Number:
d) Cheque / NEFT Payable details:
e) IFSC Code: f) MICR No:

[Please attach copy of a cancelled blank cheque of your bank for ensuring accuracy of name of the Bank, Branch name, Account number and IFSC code. If name of the policyholder is not printed on the cheque please attach copy of the first page of the bank passbook/copy of bank statement also]

Section G - Declaration by the Insured:

I hereby declare that the information furnished in this claim form is true & 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 & authorize 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 required documents for the purpose of this claim & that I will not be making any supplementary claim.

(Below declaration is to be collected from the claimant only in case of online / electronic claims submission where original documents are not submitted with Us)

"I further undertake that in consideration of You (ABHI) agreeing to process my claim based on scanned copy / photographs of medical prescription and receipt, I hereby confirm and undertake to preserve all the original documents, scanned copies / photos of which are submitted for the claim for a period of one year from the settlement of my claim and also agree to provide original copies of the same as and when required by You."

Date: D D M M Y Y Y Y

Place:

Signature of the Insured

Section H - Declaration by the Treating Doctor:

To be completed by the Medical Practitioner who originally treated the Illness or Injuries

1) Name and address of the Insured Person:

2) Gender: ☐ Male ☐ Female

3) Date of Birth: D D M M Y Y Y Y age:

4) Are you the patient's usual Medical Practitioner? ☐ Yes ☐ No

a) If yes, since when (DD/MM/YYYY)? D D M M Y Y Y Y

b) If you have treated him/her for any previous Illness or Injury, please give details:

5) Has the patient sustained a similar injury previously or aggravated a Pre-Existing Disease? ☐ Yes ☐ No (where applicable)

5) Describe nature and extent of Illness or Injury:

6) Describe the Incident (how, when and where did the Injury / Accident occur)

7) Nature and cause of Accident (so far as it is known to you) - (where applicable)

8) Was he/she under the influence of alcohol or any inebriating drugs or any other addictive substance during the Accident or not? (where applicable)

9) Whether the Injury sustained is Accidental or intentional self Injury (where applicable)

10) According to you, how long should the Insured Person be confined to bed / house as the direct and sole consequence of the Illness / Injury sustained?

I have personally examined the above named Insured Person. I certify that the above statements are correct and that the Insured Person is necessarily disabled by the Accident.

Date: D D M M Y Y Y Y

Place:

Stamp:

Signature of the Medical Practitioner:

Name & Qualification:

Registration Number:

Address:

Telephone No.: Mobile No.:

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF PROPOSER		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) Sl. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) Name	Enter the full name of the policyholder	Surname, First name, Middle name
d) Address	Enter the full postal address	Include Street, City and Pin code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yyformat
c) Company Name	Enter the full name of the insurance company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of hospitalization	Use dd-mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Mediclaim / Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to proposer	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.

f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
I) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of Injury/Date Disease first detected / Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
I) If Injury give cause	Indicate cause of injury	Tick the right option
If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
j) MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
k) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
b) Claim Documents Submitted- Check List	Indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF PROPOSER'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) & c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) Account Number	Enter the bank account number	As allotted by the bank
e) Cheque/ NEFT payable details	Enter the name of the beneficiary the cheque / NEFT should be made out to	Name of the individual
f) & g) IFSC Code & MICR Code	Enter the IFSC & MICR code of the bank branch	IFSC & MICR code of the bank branch in full
Claim payment option	Please select desired option	Tick desired option
SECTION G - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

Customer Identification Procedure (As per KYC norms of IRDAI)

Please submit a clear and legible copy of one document (valid and effective as on the date of claim submission) each from Part A and Part B and your recent passport size photograph (not more than 6 months old) in case the claim exceeds Rs 100,000

Photo:

Part A: Proof of legal name and any other names:

1. PAN CARD
2. If PAN CARD not available then please submit any of the documents mentioned below stating reason for not having Pan Card
   a. Passport
   b. Voter's Identity Card
   c. Driving License
   d. Personal Identification and Certification of the employees for your identity
   e. Letter issued by Unique identification Authority of India containing details of name address and Aadhar Number
   f. Job Card issued by NREGA duly signed by an officer of the State Government

Part B: Proof of Residence:

1. Electricity Bill not older than 6 months from the date of Insurance Contract
2. Telephone Bill pertaining to any kind of telephone connection like mobile, landline, wireless etc. Provided it is not older than 6 months from the date of claim submission
3. Ration Card
4. Valid lease agreement along with rent receipts which is not more than 3 months old as a residence proof
5. Saving Bank Passbook with details of permanent/ present residence address (updated upto 1 month prior to claim submission document)
6. Statement of saving bank account with details of present/ present address (updated upto 1 month prior to claim submission document)

I hereby declare that I have submitted above mentioned documents and recent photograph (not more than 6 months old) for the purpose of claim and the said documents are valid and effective

Date: D D M M Y Y Y Y

Signature of Claimant

Aditya Birla Health Insurance Co. Limited. IRDAI Reg.153. CIN No. U66000MH2015PLC263677.
Product Name: Activ Secure, Product UIN: ADIHLIP18076V011718.
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