Life Insurance Corporation of India

PART ' A'

Form for claiming HCB / MSB under Health Insurance Policy

(Issuance of this Claim Form does not tantamount to acceptance of Liability by the Insurer)

A. Particulars of the Policy Holder	
Name of the Policyholder (Principal Insured) :	
Name of the Claimant	
Policy Number	
Communication Address of the Policyholder / Claimant	
	Pin code:
a) Phone No	STD: No:
b) Mobile No	
c) E-Mail Address	
Name of the TPA	

B. Details of Insured Member (in respect of whom claim is made)	
a) Name of the Insured	
b) Address of the insured	
c) Occupation of the insured	
b) UHID Number on the Health Card	
c) Relationship of the Insured to PI	
d) Sex	
e) Date of Birth	
f) Details of past history with duration and initial diagnosis	

C. Particulars of Ailment/ Disease/ Injury	
a)Nature of disease / illness	
b)Date of disease / illness first detected: -	
c) Nature of Injury sustained	
d)Date of Injury sustained (in cases of Injury)	
e) Has the insured been hospitalized in the last 4 years? If yes, give details.	
f) Does the Surgery involve long period of stay /Day Care	

D. Hospitalization Expenses incurred	
a) Details of the benefits claimed: (HCB / MSB / Both)	
b) Is the claim for domiciliary hospitalization (DTB)? (If yes, please submit separate claim forms for DTB)	

D1. Hospital and treatment Particulars **(Note: If admission to more than one hospital/ICU, please fill up the details separately in the columns in page 2 below)**		
Name of the Hospital :		
Registration Number		
Address of the Hospital		
Phone Number of the Hospital	FAX No.	
In Patient No.		
a) Date of admission		Time
b) Diagnosis		
c) Date of discharge		Time
d) Duration of Hospitalisation		

E1. Particulars of Attending Doctor		
a) Name of attending Doctor/Specialization		
b) Registration No.		Telephone Number

F1. ICU Treatment Particulars	
Did the hospitalization include ICU treatment (Yes or No)	
If ICU Treatment included, please mention the following	
a) Date & time of Commencement of the ICU treatment	
b) Date & time of Completion of ICU treatment	

G1. Surgical Procedure Particulars, if any	
a) Name of Surgery	
b) Date of Surgery	
c) Name of the Surgeon who has performed the Surgery	
(Please attach all surgical reports along with the Claim Form)	

D2. Hospital and treatment Particulars (Note: If admission to more than one hospital/ICU, please fill up the details separately in the columns below)			
Name of the Hospital :			
Registration Number			
Address of the Hospital			
Phone Number of the Hospital			
FAX Number of the Hospital			
a) Date of admission		Time	
b) Diagnosis			
c) Date of discharge		Time	
d) Duration of Hospitalisation			
E2. Particulars of Attending Doctor			
a) Name of attending Doctor			
b) Registration No.		Telephone Number	
F2. ICU Treatment Particulars			
Did the hospitalization include ICU treatment (Yes or No)			
If ICU Treatment included, please mention the following			
a) Date of Commencement of the ICU treatment			Time:
b) Date of Completion of ICU treatment			Time:
G2. Surgical Procedure Particulars, if any			
a) Name of Surgery			
b) Date of Surgery			
c) Name of the Surgeon who has performed the Surgery			
(Please attach all surgical reports along with the Claim Form)			

D3. Hospital and treatment Particulars (Note: If admission to more than one hospital/ICU, please fill up the details separately in the columns below)		
Name of the Hospital :		
Registration Number		
Address of the Hospital		
Phone Number of the Hospital		
FAX Number of the Hospital		
a) Date of admission		Time
b) Diagnosis		
c) Date of discharge		Time
d) Duration of Hospitalisation		
E3. Particulars of Attending Doctor		
a) Name of attending Doctor		
b) Registration No.		Telephone Number
F3. ICU Treatment Particulars		
Did the hospitalization include ICU treatment (Yes or No)		
If ICU Treatment included, please mention the following		
a) Date & time of Commencement of the ICU treatment		
b) Date & time of Completion of ICU treatment		
G3. Surgical Procedure Particulars, if any		
a) Name of Surgery		
b) Date of Surgery		
c) Name of the Surgeon who has performed the Surgery		
(Please attach all surgical reports along with the Claim Form)		

H. Details of the Other Healthl Insurance Claims made by the Policy Holder / Claimant

Is there a simultaneous claim being made on any Health Insurance policy other than Health Plus plan of LIC of India held by the Insured Member? Is so, please give details of the policy such as – Date of commencement, amount, covered members.

Policy Number	Dt of commencement	Servicing Division	HCB covered	Remarks

Declaration by the Policy Holder / Claimant

I hereby declare that the above information is true & correct to the best of my knowledge and belief. If I have made any false, fraud or untrue statement, suppression or concealment, my right to claim under the policy shall be forfeited.

Date:

Place: **Signature of the Policyholder/Claimant**

Schedule of Expenses incurred

Date	Bill No.	Description (Mention type of Bill)	Bill issued by	Amount Claimed.	Mention type of expenses Hospitalization	Remarks
Total						

I have incurred the expenses shown above for the treatment of the disease / illness / accident.
In support of the claim, I enclose the following documents

	YES --NO		YES --NO
Policy Schedule / Policy Copy	☐ ☐	Claim Form attested by the Hospital (See Page 3)	☐ ☐
Hospital Bills / Records etc			
Hospital Final Bill*	☐ ☐	1. Hospital Payment Receipt/s	☐ ☐
Discharge Summary / Discharge card*	☐ ☐	2. MRI report/receipt	☐ ☐
Doctors Surgery Certificate if any	☐ ☐	3. CT Scan report/receipt	☐ ☐
Surgery / Consultation Bills if any	☐ ☐	4. ECG report/receipt	☐ ☐
Medicine bills with Doctors prescription	☐ ☐	5. X-ray report/receipt	☐ ☐
Investigation Reports with Doctors advice	☐ ☐	6. US Scan report/receipt	☐ ☐
Lab Reports with Doctors request No(s). of Reports	☐ ☐	7. Others (Specify)	☐ ☐
Death Certificate (if applicable)	☐ ☐		
MLC copy (if applicable)	☐ ☐		

(Copies of the bills duly attested by Hospital Authorities would suffice -Bills once submitted will NOT be returned)
*** (If more than one hospital, please attach the copies of the Discharge/Discharge Card of all the hospitals)**

Declaration

I hereby authorize the representatives of the TPA, M/s_____ and *Life Insurance Corporation of India* free and unlimited access to seek medical information (Indoor case papers, reports, documents, including photocopies thereof/pertaining my admission/treatment etc.,) from any hospital/medical practitioner from which or whom I have/the Insured member has at any time sought or shall seek medical attention concerning any disease/sickness, ailment or injury, which affects my physical or mental health.

I hereby declare that I have included all bills/ receipts for the purpose of this claim and I will not be making any supplementary claim in this regard.

I also hereby authorize the hospital/attending doctor/medical practitioner from whom I have/the Insured member has sought medical attention/medical treatment concerning any disease/sickness, ailment or injury which affected my/insured members physical/mental health to part with the above information to the TPA/LIC of India or its representatives. Myself/my successors/assigns shall not raise any dispute or litigation on passing of such information to the TPA or LIC of India or its representatives.

Date & Place

Signature of the Policy Holder /Claimant

Please Note to submit this "Claim Form" with all the enclosures to your TPA only

Claim Discharge Form

Policy No :_____

Name of the Principal Insured:_____

I hereby authorize Life Insurance Corporation of India to make payment of the above claim, admissible as per terms, conditions and limitations of the Policy. This discharge is delivered in full and final settlement of the hospital bills submitted by me and to the full satisfaction of my above mentioned claim.

1	Option to be provided by the Policyholder for Claim payment to be made by NEFT/RTGS or Demand Draft	☐ ELECTRONIC MODE OF TRANFER (For NEFT/RTGS transfer – please furnish your bank account details in question 2 below) ☐ Demand Draft
2	DETAILS OF THE BANK A/C TO WHICH THE POLICYHOLDER DESIRES TRANSFER OF CLAIM AMOUNT	NAME OF THE BANK ---------- ---------- Location ---------- Branch Code ---------- ***** A/C NO---------- IFSC NO---------- (The eleven digit number that will enable payments through RTGS/NEFT – credited into your account)

(* Please attach a cancelled cheque leaf to authenticate the details given)

The details of Bank account and address of the bank etc furnished by me above are correct and I hereby authorize Life Insurance Corporation of India to make the claim payment to my above mentioned Bank Account

DATED AT----------THIS ----------DAY OF----------200

Revenue Stamp

Place: **SIGNATURE OF THE POLICYHOLDER/ CLAIMANT**

Name : _____.

Address: _____.

_____.

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