Life Insurance Corporation of India

PART ' A'

Form for claiming HCB / MSB /OSB / Day Care benefits under LIC's Health Insurance Policies

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

I. Quick Cash facility availed (applicable for policies under plan 903 only)

Date of Major surgery	Details of Major Surgery (category 1 or 2)	Performing surgeon's name	Amount of quick cash availed

II. Benefits now Claimed under the policy

Policy Number	Daily HCB benefit of Insured (1)	No. of days Hospitalized (General ward/ICU) (2)	Total Hospital Cash Benefit Claimed (3)	Major Surgical Benefit claimed (including QCA settled, if any) (4)	Day Care Surgical Benefit claimed (5)	Other surgical benefit claimed (6)	Ambulance charges claimed (7)	Total Benefits claimed (3+4+5+6+7)

(Column 5,6,7 are applicable for policies under plan 903 only)

III. Details of the Policy Holder/Claimant/Ailment/Disease/Injury/Hospitalization expenses

A. Policy Holder

a) Name of the Policyholder (Principal Insured) :				
b) Name of the Claimant				
c) Name of the TPA				
d) Communication Address of the Policyholder / Claimant				
	Pin code:			
e) Telephone Nos.	Phone No		Mobile No	
f) E-Mail Address				
g) PAN Number				

B. 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. 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	
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	

C1. Hospitalization Expenses incurred

a) Pre-hospitalization Expenses	Rs.
b) Post hospitalization Expenses	Rs.

IV. Details of treatment/Surgery in Hospital first admitted (Please specify the type of surgery *)

D1. Hospital and treatment Particulars

Name of the Hospital :			
Registration Number			
Address of the Hospital			
Phone Number of the Hospital		Fax No.	
In Patient No.			
Claim for MSB/OSB/Day Care treatment (specify the same)*			
a) Date of admission		Time	
b) Diagnosis			
c) Date of discharge		Time	
d) Duration of Hospitalization			

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

F1. 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:	

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

V. Details of treatment/Surgery after admission in Second Hospital (after reference from the first hospital/own admission by the insured patient)

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 **(If admitted on own volition, please specify)**		Time	
b) Diagnosis			
c) Date of discharge		Time	
d) Duration of Hospitalization			

E2. Particulars of Attending Doctor				
a) Name of attending Doctor				
b) Registration No.			Tel. No.	

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 (Pl. attach all surgical reports along with the Claim Form)	
a) Name of Surgery	
b) Date of Surgery	
c) Name of the Surgeon who has performed the Surgery	

VI. Details of treatment/Surgery after admission in Third Hospital (after reference from the first/second hospital/own admission by the insured patient)

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 No	
a) Date of **admission (If admitted on own volition, please specify**)		Time	
b) Diagnosis			
c) Date of discharge		Time	
d) Duration of Hospitalization			

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 of Commencement of the ICU treatment		Time:	
b) Date of Completion of ICU treatment		Time:	

G3. Surgical Procedure Particulars, if any (Pl. attach all surgical reports along with the Claim Form)	
a) Name of Surgery	
b) Date of Surgery	
c) Name of the Surgeon who has performed the Surgery	

VII. Schedule of Expenses incurred (attach separate sheet, if necessary)

Date	Bill No.	Description (Mention type of Bill)	Bill issued by	Amount Claimed.	Mention type of expenses Pre/Post/ Hospitalization	FOR TPA USE ONLY	
						Admissible	Non Admissible
			TOTAL				

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

	YES --NO		YES --NO
Policy Schedule / Policy Copy	☐ ☐	Claim Form attested by the Hospital (See Page 3)	☐ ☐
Copy of quick cash advance application	☐ ☐		
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	☐ ☐
No. of Lab Reports with Doctors request	☐ ☐	7. Others (Specify)	☐ ☐
Death Certificate (if applicable)	☐ ☐	8. Ambulance charges paid receipt	☐ ☐
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)**

VIII. Details of other Medical/Health Insurance Claims

(On policies other than LIC Health Insurance policies) made by the Policy Holder / Claimant for the same treatment/Surgery)

Sl. No	Name of the Insured admitted for treatment	Hospital address & Location	Dates of admission & discharge	Details of treatment/Surgery	Amount of claim settled

IX. Claim settlement payment mode preferred

Please tick the option for Claim payment (For payments through NEFT/RTGS transfer (Direct credit to your Bank account)– please furnish your bank account details in a separate form attached and send the same to the servicing Divisional office immediately for data capture and settlement of the claim, if admitted)	☐ ELECTRONIC MODE OF TRANFE ☐ Cheque

---- To be torn after filling the Bank details format given on the reverse side and sent to the Division concerned for updating the records-----

Declaration

I hereby declare that all the information pertaining to the Policy, Policy Holder, Insured members who are admitted in the hospital and the Hospital treatment/Surgery ailment/disease/injury (Major/Other surgeries) furnished above is true & correct to the best of my knowledge and belief. If I have made any false, fraudulent or untrue statement, suppression or concealment, my right to claim under the policy shall be forfeited and in case any advance amount is paid under "Quick Cash", I undertake to repay the same immediately and in case of failure, the same may be recovered as arrears of revenue.
(Refund of quick cash advance declaration should also be in the QCA application form-whether it is there)

I hereby agree and authorize the Life Insurance Corporation of India to make payment of the above claim, admissible as per terms, conditions and limitations of the Policy.

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.

Authorization

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 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. I /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:

(Please note to submit this "Claim Form" with all the enclosures to your TPA only for quick processing)

Signature of the Policy Holder /Claimant

Claim Discharge Form

Policy No/s :_____

Name of the Principal Insured :_____

Name of the Insured Patient :_____

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.

Dated at----------this ----------day of----------201

Name: _____

Address: _____

Revenue Stamp
(SIGNATURE OF THE POLICYHOLDER/ CLAIMANT)

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

(Please fill up, detach the Bank details format and send to your policy servicing Division for updation or contact the nearest BO/Agent)

Bank details format

Name of the Policy Holder Name of the Bank Location Branch Code Bank A/C No. IFSC No.	_____. _____. _____. _____. _____. _____.
1. **Details of the bank a/c to which the policyholder desires transfer of claim amount** 2. **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.

Signature of the Policyholder/Claimant