Health Insurance
Aditya Birla Health Insurance Co. Limited

ADITYA BIRLA CAPITAL
PROTECTING INVESTING FINANCING ADVISING

Group Active Secure - Hospital Cash

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT
The issue of this Form is not to be taken as an admission of liability (To be filled in block letters)

SECTION A - DETAILS OF PRIMARY INSURED:

a) Policy No:

b) SI No / Certificate No.

c) Company/ TPA ID No:

d) Name:

e) Address:

City/District: State: Pin Code:

f) Phone No: g) Email ID:

SECTION B - 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:

i) Policy No. ii) Sum Insured (Rs.)

iii) Amount Claimed iv) Period of Insurance

v) Status of Claim – ☐ Paid ☐ Repudiated ☐ Under Process

vi) If Repudiated – Reason for Repudiation

d) 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:

SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name

b) Gender ☐ Male ☐ Female c) Age: Y Y years M M months

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 ☐ Tick if address is same as above

City State Pin Code

SECTION D - DETAILS OF HOSPITALIZATION:

a) Name and Address of Hospital where Admitted:

b) Diagnosis:

c) Date of Admission: D D M M Y Y Y Y d) Time:

e) Date of Discharge: D D M M Y Y Y Y f) Time:

g) Number of days in Non ICU:

h) Number of days in ICU:

SECTION E - DETAILS OF CLAIM:

a) Total Amount Claimed: b) Total Amount Claimed in words: _____

SECTION F – DOCUMENT CHECKLIST:

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) Duly filled claim form
b) Photo ID and Age proof
c) Photocopy of discharge card / day care summary / transfer summary
d) Photocopy of the final bill
e) Photocopy of previous consultation papers indicating history and treatment details for current ailment.
f) Photocopy of MLC / FIR copy – in Accidental cases only
g) Photocopy of death summary & death certificate (in death claims only)
h) Cancelled cheque copy for primary insured with pre-printed name. In case pre-printed name is not available on cheque leaf, please provide copy of bank passbook / bank statement

SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a. Pan No.: b. Account No:

c. Bank Name and Branch: _____

d. Cheque / DD Payable details: e. IFSC Code:

(IMPORTANT: PLEASE TURN OVER)

SECTION H - 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 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 & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Disclaimer: Issuance / submission of this claim form does not amount to acceptance of any liability or a waiver of any of the terms and conditions of the insurance contract.

Date: D D M M Y Y Y Y Signature of the Insured

Place:

GUIDANCE FOR FILLING CLAIM FORM		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF PRIMARY INSURED PERSON		
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) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin code
SECTION B -DETAILS OF INSURANCE HISTORY		
a) Currently covered / Previously 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-yy format
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 mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
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 primary Insured	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
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name and Address of Hospital where	Enter the name of hospital	Name of hospital in full
admitted	Enter the address of hospital	Include Street, City and Pin code
b) Diagnosis	Enter reason for hospitalization	Open text
c) Date of admission	Enter date of admission	Use dd-mm-yy format
d) Time	Enter time of admission	Use hh:mm format
e) Date of discharge	Enter date of discharge	Use dd-mm-yy format
f) Time	Enter time of discharge	Use hh:mm format
g) Number of days in Non-ICU	Enter number of days	Exact number of days to be mentioned
h) Number of days in ICU	Enter number of days	Exact number of days to be mentioned
SECTION E - DETAILS OF CLAIM		
a) Total Amount Claimed	Enter the amount claimed as per benefit	In rupees (Do not enter paise values)
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate documents checklist for claim purpose		
SECTION G - DETAILS OF PRIMARY INSURED's BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) Cheque/ DD payable details	Enter the name of the beneficiary the cheque / DD should be made out to	Name of the individual / organization in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full

SECTION H - DECLARATION BY THE INSURED
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.