SBI General Insurance Company Limited

SBI General INSURANCE

Call (Toll Free)
1800 22 1111 | 1800 102 1111
www.sbigeneral.in

HEALTH INSURANCE POLICY - RETAIL

Claim Form

Issuance of this form does not amount to admission of any liability or a waiver of any of the terms and conditions of the insurance contract. If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or any Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy shall be void and all benefits paid under it shall be forfeited.

Policy No. Claim No.

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

A. DETAILS OF INSURED/CLAIMANT

1. Name of the Insured SURNAME MIDDLE NAME FIRST NAME
2. Name of the Claimant SURNAME MIDDLE NAME FIRST NAME
3. Relationship with Insured Date of Birth D D M M Y Y Y Y
4. Gender Male Female Health Card No.:
5. Contact Details House No. Block
   Building Locality
   Street
   City District
   State Pincode
   Phone No. Mobile
   Email ID

B. DETAILS OF ILLNESS/ACCIDENT

1. Signs and symptoms of illness
2. Nature of disease/illness/injury
3. Diagnosis of illness
4. When did you first notice signs and symptoms of the illness? D D M M Y Y Y Y
5. When did you first consult your doctor for the illness? D D M M Y Y Y Y
5. When was the illness first diagnosed/detected? D D M M Y Y Y Y
6. Have you ever had the similar illness in past? Yes No
   If 'Yes', provide details,
7 Any other past history?
8 Name of the Doctor consulted first for this illness
8.1 Contact Details of the Doctor Phone No. Mobile
   E-mail Id
9. Date & Time of Admission D D M M Y Y Y Y : A.M. / P.M.
10. Date & Time of Discharge D D M M Y Y Y Y : A.M. / P.M.

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11. Type of Admission ☐ Emergency ☐ Planned ☐ Daycare

12. Type of Claim ☐ Hospitalization - Illness ☐ Hospitalization - Accidental ☐ Hospitalization - Domiciliary ☐ Pre Hospitalization ☐ Post Hospitalization ☐ Parental Care Benefit ☐ Child Care Benefit ☐ Convalescence Benefit

13. Type of Hospital ☐ Network ☐ Non-Network

14. Type of Treatment ☐ Allopathic ☐ Ayurvedic ☐ Homeopathic ☐ Unani

15. Name of the Hospital

16. Name of treating Doctor

17. Qualification of treating Doctor   Treating Doctors Registration No.

18.1Address of the Hospital   Plot No/Door No.   Building Name

Road   Area

City   District

State   Pincode

18.2Contact Details   Phone No.   Mobile

E-mail Id

19. Name, address & telephone no. of Family Doctor

C. DETAILS OF PREVIOUS HEALTH CLAIM

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

If 'Yes', please provide details ____________________

D. DETAILS OF OTHER HEALTH INSURANCE/INTEREST

1. Is the illness / disease covered under any other Insurance? ☐ Yes ☐ No

If 'Yes', specify details and attach copy of the said Policy

Name of Insurer

Policy Number

Name of TPA

E. SCHEDULE OF EXPENSES INCURRED BY THE CLAIMANT UNDER HOSPITALIZATION

1. Please tick (✓) specifying nature of claim as follows along with the expense details:

Sr. No.	Expense Details	Amount (Rs.)
A	Hospitalization Expenses	
B	Pre-hospitalization Expenses	
C	Post-hospitalization Expenses	
D	Day Care Hospitalization	
E	Domiciliary Treatment expenses	
F	Maternity Expenses	
G	Emergency Ambulance Expenses	
H	Other expenses not included above	
I	Other expenses not included above	
	Total Amount Claimed	

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Please provide break up of expenses incurred by claimant

Description	Claimed Amount (Rs.)
Room and Board Expenses (No. of days x Amount / day)	
Intensive Care Unit Expenses (No. of days x Amount / day)	
Investigations Expense	
Medicines Expense	
Doctor Consultation / Visit Expense	
Surgeon Expense	
Anesthetist Expense	
Operation Theatre Expense	
Consumables Expense	
Registration / Service Expense	
Ambulance Expenses	
Parental Care Benefit	
Child Care Benefit	
Convalescence Benefit	
Other Expenses not included above	
Other Expenses not included above	
GRAND TOTAL	

F. ENCLOSURE CHECKLIST

- ☐ Claim Form duly filled & signed
- ☐ Policy Copy
- ☐ Discharge Card / Certificate
- ☐ Hospitalization Bills
- ☐ Medicine Bills
- ☐ Investigation Bills
- ☐ Valid Photo Identity Card
- ☐ Medical Certificate
- ☐ FIR/ MLC copy
- ☐ Death Certificate (if applicable)
- ☐ Investigation Reports
- ☐ Doctor's Prescription
- ☐ Any other documents

Any other documents, please specify ______________________________

G PAYEE DETAILS

1. Name of Proposer
2. Payable Details ☐ Cheque ☐ NEFT

Bank Name

Bank Branch

Bank Account No.

IFSC Code

MICR No.

PAN No.

Note: It is agreed that the Policyholder/Claimant will intimate in writing to SBI General about any change in bank account details. Please attach a cancelled cheque pertaining to the same account.

H. DETAILS OF OTHER INFORMATION

Do you wish to provide any other information? ☐ Yes ☐ No

If 'Yes', specify

____

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I/We, the above named, do hereby warrant the truth of foregoing statements in every respect and to the best of my/our knowledge and belief. I/We agree that if I /We have made or make any further declaration (that the Company may require in respect of the said claim) any false of fraudulent statement or any suppression or concealment, my/our Claim shall be absolutely forfeited and the Policy shall be null and void and my/our all rights uin respect of past or future loss/accident shall be forfeited.

Place | | | | | | | | | | | | | | | | |

Signature of Claimant ______________________

Date: D D M M Y Y Y Y

Name of Insured/Claimant ______________________

I. DETAILS TO BE FILLED BY HOSPITAL

1. Name of the patient

IP Registration No.

Description

a. Primary Diagnosis ______________________

b. Additional Diagnosis ______________________

c. Procedure 1 ______________________

d. Procedure 2 ______________________

e. Procedure 3 ______________________

f. Details of Procedure ______________________

2. Pre-authorization Obtained ☐ Yes ☐ No

If Yes, Pre-authorization No.

If authorization is not obtained by network hospital please give reason ______________________

Is Hospitalization due to injury? ☐ Yes ☐ No

If Yes, ☐ Self inflicted ☐ RTA ☐ Any Other

If injury due to substance abuse / alcohol consumption? ☐ Yes ☐ No

Was test conducted to establish substance abuse? ☐ Yes ☐ No

Medico legal ☐ Yes ☐ No

Reported to police ☐ Yes ☐ No

FIR No.

If not reported to Police give reason ______________________

I certify that I have examined the above named insured, the above statements are correct and that the above named insured is necessarily suffered from the illness mentioned.

Place

Date: D D M M Y Y Y Y

Stamp and Signature of the Hospital Authority

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