IFFCO-TOKIO GENERAL INSURANCE
Muskurate Raho

CLAIM FORM - PART A
IFFCO TOKIO GENERAL INSURANCE COMPANY LIMITED
TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability **(To be filled in block letters)**

DETAILS OF PRIMARY INSURED:

a) Policy No: b) Sl. No/ Certificate No:
c) Company/ TPA ID No:
d) Name:
e) Address:
City: State :
Pin Code: Phone No: Email ID:

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: Yes No b) If yes, company name:
Policy No. Sum Insured (Rs.)
c) Date of commencement of first Insurance without break: D D M M Y Y (Copies of Policies to be attached)
d) Have you been hospitalized in the last 4 years? (since inception of the contract) Yes No Date: M M Y Y Dignosis:
e) Previously covered by any other Mediclaim / Health Insurance: Yes No f) If yes, Company Name:

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name:
b) Gender: Male Female c) Age : years Y Y months M M 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 Employee Homemaker Student Retired Other (Please Specify)
Address (if different from above):
City: State :
Pin Code: Phone No: Email ID:

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 Meternity d) Date of Injury / Date of Disease first detected / Date of Delivery D D M M Y Y
e) Date of Admission: D D M M Y Y f) Time: H H : M M g) Date of Discharge: D D M M Y Y h) Time: H H : M M
i) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol consumption I. if Medico legal: Yes No
II. Reported to police: Yes No III. MLC Report & Police FIR attached: Yes No j) System of Medicine:
j) Date of Surgery: D D M M Y Y k) Claim Intimated: Yes No i. Intimated to whom: V SBU / Intermediaries / Call Centre / Health Claims Team
ii. Intimation No.& date D D M M Y Y iii. If not Intimated, reason?

DETAILS OF CLAIM:

a) Details of the treatment expenses claimed

i. Pre-hospitalization Expenses: Rs.
ii. Hospitalization Expenses: Rs.
iii. Post-hospitalization expenses: Rs.
iv. Health-Check up Cost: Rs.
v. Ambulance Charges: Rs.
vi. Others (code): Rs.
Total Rs.
vii. Pre-hospitalization period: days
viii. Post hospitalization period: days
b) Claim for Domiciliary Hospitalization: Yes No (If yes, provide details in annexure)
c) Details of Lump sum / cash benefit claimed:
i. Hospital Daily Cash: Rs.
ii. Surgical Cash: Rs.
iii. Critical Illness Benefit: Rs.
iv. Convalescence: Rs.
v. Pre/Post hospitalization Lump sum benefit: Rs.
vi. Others: Rs.
Total Rs.

Claim Documents Submitted - Check List:

- Claim Form Duly signed
- Copy of the claim intimation
- Hospital Main Bill
- Hospital Break - up Bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theatre Notes
- ECG
- Doctor's request for investigation
- Investigation Reports (CT / MRI / USG / HPE)
- Doctor's Prescriptions
- Others

DETAILS OF BILLS ENCLOSED:

Sl No.	Bill No.	Date	Issued By	Towards (Hospitalization / Pre-hospitalization / Post-Hospitalization)	Amount (Rs)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Do you want to opt for Automatic Reinstatement of Sum Insured in the event of a claim? If, Yes, applicable premium at short period rates would be deducted from the claim amount due to you. This reinstated sum will not be available for the same hospitalization. It will be available for treatment (other than certain chronic diseases) including the same illness or disease but separate independent case of hospitalization which are not case of relapse within 45 days of first hospitalization. Please contact the agent / our office for further details: **Yes / No**

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT (PLEASE SUBMIT A CANCELLED CHEQUE COPY FOR NEFT)

a) PAN: b) Account Number:
c) Bank Name and Branch:
d) Cheque / DD Payable details: e) IFSC Code :

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 meterial 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.

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

Important:
1- Please submit copy of valid Photo ID.
2- For claimed amount above 1 lac, it is mandatory to submit the KYC (Know your customer) form