Liberty Videocon General Insurance

CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED (To be filled in block letter)

The issue of this form is not to be taken as an admission of liability

SECTION A

DETAILS OF PRIMARY INSURED

a) Policy No : b) SI. No/certificate No :

c) Company / TAP ID No :

d) Name : SURNAME FIRST NAME MIDDLE NAME

e) Address :

City : State :

Pin Code : Phone No : 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 (copy of policies to be attached)

c) If Company Name : Policy No :

Sum Insured (Rs.) :

d) Have you been hospitalized in the last 4 year? ☐ Yes ☐ No Date : d d m m y y Diagnosis :

e) Previously covered by any other Mediclaim / Health Insurance : ☐ Yes ☐ No f) If Yes, Company Name :

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name : SURNAME FIRST NAME MIDDLE NAME

b) Gender : ☐ Male ☐ Female c) Age : Year y y Months m m d) Date of Brith d d y y m m

e) Relationship to Primary Insured : ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please specify)

f) Occupation : ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please specify)

e) Address (if different from Above) :

City : State :

Pin Code : Phone No : Email ID :

SECTION D

DETAIL 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 ☐ Maternity d) Date of Injury / Date Disease First Detected / Date of Delivery : d d y y m m

e) Date of Admission : d d y y m m f) Time : h h m m g) Date Of Discharge : d d y y m m h) Time : h h m m

i) If Injury Give Cause : ☐ Self Inflicted ☐ Road Traffic Accident ☐ Substance / 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 :

SECTION E

DETAIL 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. Other (code) : Rs.

Total **Rs.**

vii. Pre-hospitalisation period : days

viii. Post-hospitalization Period : days d d y y m m

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.

ii. Critical Illness Benefit : Rs.

iv. Convalescence : Rs.

v. Pre/Post Hospitalization Lump Sum Benefit : Rs.

vi. Other : Rs.

Total **Rs.**

(IMPORTANT : PLEASE TURN OVER)

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SECTION E

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 Theater Notes
- ☐ ECG
- ☐ Doctor's Request For Investigation
- ☐ Investigation Report (Including CT / MRI/ USG / HPE)
- ☐ Other

SECTION F

DETAILS OF BILL ENCLOSED

Sl. No	Bill No	Date	Issued by	Towards	Amount (RS)
1.		d d m m y y		Hospital Main Bill	
2.		d d m m y y		Pre-hospitalization: _____ Nos	
3.		d d m m y y		Pre-hospitalization: _____ Nos	
4.		d d m m y y		Pharmacy Bills	
5.		d d m m y y			
6.		d d m m y y			
7.		d d m m y y			
8.		d d m m y y			
9.		d d m m y y			
10.		d d m m y y			

SECTION G

DETAILS PRIMARY INSURED'S ACCOUNT

a) Pan :

b) Account Number :

c) Bank Name and Branch :

d) Cheque/ DD Payable details :

e) IFSC Code :

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, 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