IFFCO-TOKIO GENERAL INSURANCE

CLAIM FORM - PART A
IFFCO TOKIO GENERAL INSURANCE COMPANY LIMITED
CIN: U74899DL2000PLC107621
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) SI. No/ Certificate No: c) Member/Client ID No: X X - X X X X X X X X - X X

d) Name:

e) Address:

City:

State : Pin Code: Email ID:

Phone No: Moble No. f) Policy Type Individual Corporate g) Employee ID

g) Corporate/ Group Name h) On the date of hospitalization, are you an employee/member of the group Yes No

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) Have you been covered by any other Mediclaim / Health Insurance in last 4 years: 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 with 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: √ 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
- Investigation Reports (CT / MRI / USG / HPE)
- Doctor's request for investigation
- Operation Theatre Notes
- ECG
- Pharmacy Bill
- Doctor's Prescriptions
- Pre Hosp Bills
- Post Hosp. Bills
- Others

DETAILS OF BILLS ENCLOSED: (Use separate sheet if required)

Sl No.	Bill No.	Date	Issued By	Towards (Hospitalization / Pre-hospitalization / Post-Hospitalization)	Amount (Rs)
1		D D M M Y Y			
2		D D M M Y Y			
3		D D M M Y Y			
4		D D M M Y Y			
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			

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

IFFCO-TOKIO GENERAL INSURANCE
Muskurate Raho

CLAIM FORM - PART B
IFFCO TOKIO GENERAL INSURANCE COMPANY LIMITED
CIN: U74899DL2000PLC107621
TO BE FILLED IN BY THE HOSPITAL
The issue of this Form is not to be taken as an admission of liability
Please include the original preauthorization request form in lieu of PART A

(To be filled in block letters)

A. DETAILS OF HOSPITAL

a) Name of the Hospital:
b) Hospital ID: c) Type of Hospital: Network ☐ Non Network ☐ (If non network fill section E)
d) Name of the treating doctor:
e) Qualification: f) Registration No. with State Code: g) Phone No.

B. DETAILS OF THE PATIENT ADMITTED:

a) Name of the Patient:
b) IP Registration Number: c) Gender: Male ☐ Female ☐ d) Age: Years Y Y months M M e) Date of birth: D D M M Y Y
f) Date of Admission: D D M M Y Y g) Time: H H : M M h) Date of Discharge: D D M M Y Y i) Time: H H : M M
j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i. Date of Delivery: D D M M Y Y Gravida Statu
l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐ m) Total Claimed Amount: Rs.

C. DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 Codes	Description
i. Primary Diagnosis:			i. Procedure 1:		
ii. Additional Diagnosis:			ii. Procedure 2:		
iii. Co-morbidities:			iii. Procedure 3:		
iv. Co-morbidities:			iv. Details of Procedure:		

c) Present ailment is a complication of PED? ☐ Yes ☐ No (If Yes, specity details)
d) Pre-authorization obtained: ☐ Yes ☐ No e) Pre-authorization Number:
f) If authorization by network hospital not obtained, give reason:
g) Hospitalization due to Injury: ☐ Yes ☐ No i. If Yes, give cause Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption ☐
ii. If Injury due to Substance abuse / alcohol consumption. Test Conducted to establish this: ☐ Yes ☐ No (If Yes, attach reports) iii. If Medico legal: ☐ Yes ☐ No iv. Reported to Police: ☐ Yes ☐ No
v. FIR no. vi. If not reported to police give reason:

D. CLAIM DOCUMENTS SUBMITTED - CHECK LIST

☐ Claim Form duly signed	☐ Operation Theatre notes	☐ Doctor's reference slip for investigation
☐ Original Pre-authorization request	☐ Hospital main bill	☐ ECG
☐ Copy of the Pre-authorization approval letter	☐ Hospital break-up bill	☐ Pharmacy bills
☐ Copy of photo ID card of patient verified by hospital	☐ Investigation reports	☐ MLC report & Police FIR
☐ Hospital Discharge summary	☐ CT/MR/USG/HPE investigation reports	☐ Original death summary from hospital where applicable
☐ Any other, please specify		

E. ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital:
City: State: Pin Code:
b) Phone No. c) Registration No.: Date of Registration: D D M M Y Y
Expiry date of Registration D D M M Y Y Name of the Registering Authority:
d) PAN: e) Number of Inpatient beds f) Facilities available in the hospital: i. OT: ☐ Yes ☐ No ii. ICU: ☐ Yes ☐ No
iii. Others:

F. DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any meterial fact, our right to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Hospital have required infrastructure to fulfill the hospital definition as per IRDA guideline, which is reproduced below-

- Has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places
- Has fully qualified nursing staff under its employment round the clock
- Has fully qualified doctor(s) in charge round the clock
- Has a fully equipped operation theatre of its own where surgical procedures are carried out.
- Maintains daily Medical records of patients and will make these accessible to the Company's authorized personnel.

Date: D D M M Y Y Place:

Signature of Insured / Claimant:

Signature and Seal of the Hospital Authority: