# CLAIM FORM

TATA AIG INSURANCE
WITH YOU ALWAYS

## (Part-A)

To be filled in by the insured . The issue of this Form is not to be taken in as admission of liability
Please fill-up this form in **CAPITAL LETTERS**

## DETAILS OF PRIMARY INSURED (SECTION A)

Policy No:

Sl. No. Certification No: Company TPA ID No:

Name (Mr/Mrs/Ms/Dr):
First Name Middle Name Surname

Address:

Landmark

Area

City/Town District

Pin Code State

E-Mail

Phone

## DETAILS OF INSURANCE HISTORY (SECTION B)

Currently covered by any other Mediclaim/Health Insurance: Yes ☐ No ☐

Date of commencement of first insurance without break : D D M M Y Y Y Y

If yes, Company Name:

Policy No: Sum Insured (Rs.):

Have you been hospitalized in the last four years since inception of the contract? Yes ☐ No ☐

Date: D D M M Y Y Y Y Diagnosis: ________________________________

Previously covered by any other Mediclaim/Health Insurance: Yes ☐ No ☐

If yes, Company Name:

## DETAILS OF INSURED PERSON HOSPITALIZED (SECTION C)

Name (Mr/Mrs/Ms/Dr):
First Name Middle Name Surname

Gender: Male ☐ Female ☐ Date of birth: D D M M Y Y Y Y Age ☐☐ Years ☐☐ Months

Relationship to Primary Insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ (Please Specify) _________

Occupation: Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐
(Please Specify) ________________________________



Regd Office: 15th Floor, Tower A, Peninsula Business Park, G. K. Marg, Lower Parel, Mumbai - 400 013
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IRDA of India Registration No: 108 • Website: **www.tataaig.com** • CIN: U85110MH2000PLC128425

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Address:

Landmark

Area

City/Town    District

Pin Code    State

E-Mail

Phone

## DETAILS OF HOSPITALIZATION (SECTION D)

Name of Hospital: where Admitted

Room Category occupied: Day Care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐

Hospitalizaton due to: Injury ☐ Illness ☐ Maternity ☐

Date of injury/Date Disease first detected/Date of Delivery : D D M M Y Y Y Y

Date of Admission: D D M M Y Y Y Y    Time: H H M M

Date of Discharge: D D M M Y Y Y Y    Time: H H M M

If Injury give cause: Self Inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption ☐

If Medico legal Yes ☐ No ☐

Reported to police Yes ☐ No ☐

MLC Report & Police FIR attached Yes ☐ No ☐

System of Medicine

## DETAILS OF CLAIM (SECTION E)

Details of the treatment expenses claimed:

Pre-hospitalization Expenses Rs.    Hospitalization Expenses Rs.

Post-hospitalization Expenses Rs.    Health-Check up Cost Rs.

Ambulance Charges Rs.    Other (Code) ☐ Rs.

**Total Rs.**

Pre-hospitalization period: days    Post-hospitalization period: days

Claim for Domiciliary Hospitalization: Yes ☐ No ☐ (If yes, provide details in annexure)

Details of Lump sum/cash benefit claimed

Hospital Daily Cash Rs.    Surgical Cash Rs.

Critical Illness Benefit Rs.    Convalescence Rs.

Pre/Post hospitalization Lump sum benefit Rs.    Other Rs.

**Total Rs.**

## CLAIM DOCUMENTS SUBMITTED-CHECK LIST

- ☐ Claim Form duly signed
- ☐ Hospital Main Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Pharmacy Bill
- ☐ ECG
- ☐ Investigation Reports (Including CT/MRI/USG/HPE)
- ☐ Copy of the claim intimation, if any
- ☐ Hospital Break-up Bill
- ☐ Hospital Discharge Summary
- ☐ Operation Theatre Notes
- ☐ Doctor’s request for investigation
- ☐ Doctors Prescription
- Others ☐



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## DETAILS OF BILLS ENCLOSED: (SECTION F)

| Sl. No. | Bill No. | Date | Issued by | Towards | Amount |
|---|---|---|---|---|---|
| 1 | | D \| D \| M \| M \| YYYY | | Hospital Main Bill | |
| 2 | | D \| D \| M \| M \| YYYY | | Pre-hospitalization Bills ______ Nos. | |
| 3 | | D \| D \| M \| M \| YYYY | | Post-hospitalization Bills ______ Nos. | |
| 4 | | D \| D \| M \| M \| YYYY | | Pharmacy Bills | |
| 5 | | D \| D \| M \| M \| YYYY | | | |
| 6 | | D \| D \| M \| M \| YYYY | | | |
| 7 | | D \| D \| M \| M \| YYYY | | | |
| 8 | | D \| D \| M \| M \| YYYY | | | |
| 9 | | D \| D \| M \| M \| YYYY | | | |
| 10 | | D \| D \| M \| M \| YYYY | | | |

## DETAILS OF PRIMARY INSURED BANK ACCOUNT: (SECTION G)

PAN Card: Account No:

Bank Name and Branch:

Cheque/DD Payable details: ______________________ IFSC Code:

## DECLARATION BY THE INSURED (SECTION H)

I hereby declare that the information furnished in this Claim From 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.

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

Place ______________________

## GUIDANCE FOR FILLING CLAIM FORM-PART A (To be filled in by the insured)

| Sl. No. | DATA ELEMENT | DESCRIPTION | FORMAT |
|---|---|---|---|
| | SECTION A: DETAILS OF PRIMARY INSURED | | |
| 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 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 |



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| Sl. No. | DATA ELEMENT | DESCRIPTION | FORMAT |
|---|---|---|---|
| e. | Previously Covered by any other Mediclaim/Health Insurance? | Indicate whether previously covered by another Mediclaim/Health Insurance? | Tick Yes or No |
| f. | Company Name | Enter the full name of the insurance company | Name of the organization in full |
| | 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.<br>If others, please specify. |
| f. | Occupation | Indicate occupation of patient | Tick the right option.<br>If others, please specify. |
| g. | Address | Enter the full postal address | Include Street, City and Pin Code |
| h. | Phone No. | Enter the phone number of patient | Include STD code with telephone number |
| i. | E-mail ID | Enter e-mail address of patient | Complete e-mail address |
| | SECTION D: DETAILS OF HOSPITALIZATION | | |
| a. | Name of Hospital where admitted | Enter the name of hospital | Name of hospital in full |
| b. | Room category occupied | Indicate the room category occupied | Tick the right option |
| c. | Hospitalization due to | Indicate reason of hospitalization | Tick the right option |
| d. | Date of Injury/Date Disease first detected/Date of Delivery | Enter the relevant date | Use dd-mm-yy format |
| e. | Date of admission | Enter date of admission | Use dd-mm-yy format |
| f. | Time | Enter date of admission | Use hh-mm format |
| g. | Date of discharge | Enter date of discharge | Use dd-mm-yy format |
| h. | Time | Enter date of discharge | Use hh-mm format |
| i. | If Injury give cause | Indicate cause of injury | Tick the right option |
| | If Medico legal | Indicate whether injury is medico legal | Tick Yes or No |
| | Reported to Police | Indicate whether police report was failed | Tick Yes or No |
| | MLC Report & Police FIR attached | Indicate whether MLC report and Police FIR attached | Tick Yes or No |
| j. | System of Medicine | Enter the system of medicine followed in treating the patient | Open Text |
| | SECTION E: DETAILS OF CLAIM | | |
| a. | Details of Treatment Expenses | Enter the amount claimed as treatment expenses | In rupees (Do not enter paise values) |
| b. | Claim for Domiciliary Hospitalization | Indicate whether claim is domiciliary hospitalization | Tick Yes or No |
| c. | Details of Lump sum/cash benefit claimed | Enter the amount claimed as lump sum/cash benefit | In rupees (Do not enter paise values) |
| d. | Claim Documents submitted-Check List | Indicate which supporting documents are submitted | Tick the right option |
| | SECTION F: DETAILS OF BILLS ENCLOSED | | |
| Indicate which bills are enclosed with the amounts in rupees | | | |
| | 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. | | | |