

HOSPITAL CASH BENEFIT CLAIM FORM

Lodged at:

Head Office:

Branch Office: _____

(To be completed by the Policy Owner)

General instructions and warnings:

- While answering questions in the claim form and providing any other information in respect of the claim, the Policy Owner must make a full and frank disclosure of all material facts.
- Please read the policy document carefully to avail the benefits under the policy.
- All corrections made in the claim form have to be duly countersigned in full.
- All the answers must be clear and unambiguous.
- If the space provided is insufficient, please attach the annexures along with this form.
- Please submit the requisite documents along with the claim form for a faster processing.
- The company retains the right to call for further evidence needed to process the claim.
- Submission of form duly acknowledged by us does not amount to admission of claim.
- **As per the Know Your Customer (KYC) norms, certain KYC documents of the claimant(s) would be required for the processing of the claim.**

Checklist of the documents to be submitted in case of Hospital Cash Rider benefit

- Hospital Cash Benefit claim form (available on the website/will be provided by the claims department).
- Attested copies of all test reports/X Ray films
- Discharge summary from hospital with a report of treating physician / operating surgeon and any other related report(s).
- Attending physician's statement on the general health and prognosis of the insured for the illness suffered (to be filled up by the Last attending physician or the family physician that the insured consults).
- Final bill issued by the hospital with date and time of admission and discharge.
- Proof of residence and identity of the policyowner/ Life insured (KYC)
- Others (as required by IDBI Federal)

Note:

- 1 If copies of any documents are being submitted then, they need to be attested by the respective authorized signatories / entities from where they were issued.
- 2 Depending on the facts and circumstances of the claim, the Company reserves the right to call for certain additional documents.

Name of the Life Insured:

Claim No: _____ Policy No(s): _____ Sum Insured: _____

1. Particulars of Policy Owner:

- Full Name _____
- Address and Telephone no. _____

- Email ID & Fax No. _____
- Bank account no., Name of the Bank and address (mandatory) _____

2. Particulars of complaints or symptoms:

- Types of complaint(s) _____

- Date of disease (first diagnosis/surgery) _____
- Date and time of admission _____
 - To hospital _____
 - To ICU (if applicable) _____

- iv. Exact diagnosis (es)/condition(s) _____
- v. Investigations undergone _____
- vi. Treatment given _____
- vii. Details of treatment given for any other illness/ accident _____
- viii. Date and time of discharge _____
- ix. Details of occupation, address and tel. numbers of the employer(s) _____

3. Particulars of doctors consulted and hospital / medical centre wherein the insured was admitted currently or for any other previous illness:

S. No.	Name of Hospital and/or Doctors	Date of first consultation	Address	Date of admission and operation	Date of discharge

4. Details of policies on the life insured taken with other life insurance companies:

S. No.	Base policy benefit	Base amount	Policy no.	Insurer	Effective Date	Riders

5. DECLARATION AND AUTHORISATION:

I _____ do solemnly declare and confirm that the foregoing answers and statements are true and complete in all respects.

I hereby authorize any medical practitioner or hospital or nursing home or medical clinic who or which has attended upon or examined or treated me/Life Insured for any ailment or illness to divulge any knowledge or information regarding my/Life Insured's state of health which he / they may have acquired before or after the issuance of the policy, to IDBI Federal Life Insurance Co Ltd, any of its offices or Court of law, or any grievance redressal forum. I hereby confirm that this authorization is notwithstanding any law, custom or usage for the time being in force prohibiting any physician or hospital from divulging any knowledge or information, acquired by him/ them in attending upon or examining a person on the ground of secrecy.

Further, I hereby authorize any insurance company, government organization, employer, other organization, institution or person to release to IDBI Federal Life Insurance Co Ltd or its duly authorized representatives any record or knowledge of my/Life Insured. I hereby confirm that such information shall without limitation include information about Life Insured's health (including any information relating to the use of drugs or alcohol, AIDS, or mental and physical history, condition, advice or treatment), earnings or other insurance benefits, including any accounting information of my/Life Insured's account.

I hereby declare that I am entitled to make the above authorizations. I also agree to render help to IDBI Federal Life Insurance Co Ltd or its duly authorized representatives to gather the said information or any information that may help the company to process this claim and to use the information in whatever manner as may be deemed to be fit to process this claim further.

Address and Telephone no: _____

Signature / Thumb impression of the Policy Owner _____

Place: _____

Date: _____

6. Witness Declaration:

(The below Declaration is to be given if claim form is signed in vernacular or if the Policy Owner has used thumb impression instead of signature.)

I have explained the contents of this claim form to the Policy Owner in _____ (language) and ensured that the contents have been fully understood by him/her. I have accurately recorded the Policy Owner's responses to the information sought in the claim form. I have read out the responses to the Policy Owner and he/she has confirmed that they are correct and affixed his/her thumb impression after fully understanding the same.

Signature of the Witness/ Declarant: _____

Name of Witness/ Declarant: _____

Address: _____

Signature of the Witness/Declarant: _____

Place: _____ Date: _____