CLAIM FORM & OTHER DOCUMENTS TO BE SUBMITTED TO LIC BRANCH/ DIVISIONAL OFFICES ONLY

LIC भारतीय जीवन बीमा निगम LIFE INSURANCE CORPORATION OF INDIA

Form for claiming HCB/ MSB/ DCPB/ OSB/ Quick Cash under LIC's Health Insurance Policy
(Issuance of this Claim Form does not tantamount to acceptance of Liability by the Insurer)

Benefits under the policy are fixed as per Daily Benefit opted by you at proposal stage and has no relation to actual expenses incurred by you before, during or after hospitalization.

Policy Number	UHID NO.of Health Card	Name of the TPA	Mobile / Phone of Principal Insured	E-mail ID of Principal Insured

1. Quick Cash facility availed (applicable for policies under plan 903 only)

Date of Major surgery	Details of Major Surgery (category1 OR 2)	Performing Surgeon's Name	Amount of Quick Cash Availed

2. Benefits now claimed under the policy

A. Daily Hospital Cash Benefit of Insured	B. No. of days Hospitalized	C. Daily Hospital Cash Benefit Claimed	D Major Surgical Benefit Claimed	E. Total Benefits Claimed(C+D)

A . PARTICULARS OF THE POLICY HOLDER

Name of the Policyholder(Principal Insured)	
Communication Address of the Policyholder	
C .PARTICULARS OF AILMENT/ DISEASE/ INJURY	
Nature of disease/illness/injury	
Date of disease/ illness/ injury first detected	
Has the insured been hospitalized in the past? If yes give details	

B. DETAILS OF INSURED MEMBER (In respect of whom claim is made)

Name of the Insured	
Occupation of the Insured	
Address of the Insured	
Relationship of the Insured to PI	
SEX (M / F) :	Date of Birth:
Details of past history of disease with initial diagnosis	
Duration of disease:	
In case of Road Traffic Accident , whether MLC / FIR lodged: YES / NO **If "YES" Please attach reports**	

D. HOSPITAL AND TREATMENT PARTICULARS

Name of the Hospital:		Phone Number of the Hospital	
Registration No.		FAX No of the Hospital:	
Address of the Hospital		In patient No.	
		Date of Admission:	Time:
		Date of Discharge:	Time:
		Diagnosis:	

Covered by any other Health insurance: Give Name of the Company & Pol No:

E .PARTICULARS OF ATTENDING DOCTOR

Name of Attending Doctor & his specialisation	
Registration No:	System of Medicine: Allopathy / Non-Allopathy:

F. ICU TREATMENT PARTICULARS

Did the hospitalization include ICU treatment	YES / NO		
If **"YES",** Date of commencement of ICU treatment / Time			
Date of completion of ICU treatment/Time			

G. SURGICAL PROCEDURE PARTICULARS, IF ANY

Name of surgery	
Date of Surgery	
Name of surgeon who has performed the surgery	
Please attach all surgical reports along with this form	

Declaration by the policyholder / Claimant

I hereby declare that the above information is true & correct to the best of my knowledge and belief. If I have made any false, fraudulent or untrue statement, or suppressed or concealed answers to the above questions, my right to claim under the policy shall be forfeited.

Date: **Place:** **Signature of the policyholder/Principal Insured**

Claim Discharge Certificate

NAME OF THE BANK/CODE NO.....

Location ----------

A/C NO----------

IFSC NO----------

PAN NO ----------

Please attach a cancelled cheque leaf to authenticate the details given above

The details of Bank account and address of the Bank etc furnished by me are correct and I hereby authorize Life Insurance Corporation of India to make the claim payment to my above mentioned Bank Account.

Date: **Signature of the Principal Insured**

I hereby authorize Life Insurance Corporation of India to make payment of the above claim, admissible as per terms, conditions and limitations of the Policy. This discharge is delivered with full satisfaction in full and final settlement of my above mentioned claim.

Revenue Stamp

Date: **Signature of the Principal Insured**
Place:

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