

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



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)

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 (category 1 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

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

Name of the Policyholder(Principal Insured)	Name of the Insured
Name of the TPA	Occupation of the Insured
Communication Address of the Policyholder	Address of the Insured

C. PARTICULARS OF AILMENT/ DISEASE/ INJURY

Nature of disease/illness/injury	Relationship of the Insured to PI	Date of Birth:
	SEX (M / F) :	
Date of disease/ illness/ injury first detected	Details of past history of disease with initial diagnosis	
Has the insured been hospitalized in the past? If yes give details	Duration of disease:	
	In case of Road Traffic Accident , whether MLC / FIR lodged: YES / NO	
	If "YES" Please attach reports	

D1. 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:

E1 .PARTICULARS OF ATTENDING DOCTOR

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

F1. ICU TREATMENT PARTICULARS

G1. SURGICAL PROCEDURE PARTICULARS, IF ANY

Did the hospitalization include ICU treatment	YES / NO	Name of surgery	
		Date of Surgery	
If "YES", Date of commencement of ICU treatment / Time		Name of surgeon who has performed the surgery	
Date of completion of ICU treatment/Time		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

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: _____
Place: _____ Signature of the Principal Insured

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