SBI Life INSURANCE With Us, You're Sure

CLAIM FORM
SBI LIFE – HOSPITAL CASH

INSURED DETAILS

Name of Insured for whom the claim is lodged: _____
Policy Number: _____Customer ID Number:_____
Address of the Insured: _____
_____
_____
City:_____State_____
E-mail ID _____ Tel No: _____
Date of Birth: dd/mm/yyyy
Is the insured covered under any hospital cash policy with SBI Life: Yes ☐ No ☐
If Yes then, Policy Numebr: _____

CLAIM DETAILS

Diagnosis of illness/ disease :	
Date of diagnosis dd/mm/yyyy	Date of first consultation dd/mm/yyyy
Date of Admission dd/mm/yyyy	Date of discharge dd/mm/yyyy
No of days in Ward_____	No of days in ICU _____

CASES DUE TO ACCIDENT

Is the hospitalization due to accident? Yes ☐	No ☐
Date of Accident dd/mm/yyyy :	FIR No.
Police Station name and address:	

Brief narration of how the accident happened (if accidental hospitalization):
_____
_____
_____

HOSPITAL AND TREATING DOCTOR'S DETAILS

Name of the Hospital: _____
Address of the Hospital: _____ __
_____
_____
City: _____State_____
Tel No: _____
No of In-patient beds: _____ _____
Name of the treating doctor under whom the admission was taken: _____
_____
Qualification of the doctor: _____

	Name of the Treating Doctor(s)	Contact Number	Date of First consultation	Treatment Taken

Is the insured suffering from any pre-existing disease or was the treatment taken in hospital related to any pre-existing disease? Yes No
If Yes Provide details of disease including the name and time since suffering: _____
_____
_____

PLEASE TICK ON THE FOLLOWING DOCUMENTS ATTACHED WITH CLAIM FORM

Copy of policy document ☐	Valid age proof* ☐ ☐ ☐
Hospital Discharge card	Treating doctor's certificate confirming admission and diagnosis
Copy of medical Records	Hospital bill Payment receipts

CLAIMING FOR FAMILY CARE BENEFIT Yes ☐ No ☐

IF YES: Name of the other insured who has been hospitalized for the same ailment continuously for a period of 5 or more consecutive days: _____

_____

BANK DETAILS OF THE INSURED/ CLAIMANT	
Name of Bank	
Branch Code Number	
IFCS Code Number	
Account Number	
Address of the Bank	

DECLARATION

I /We, the above-named Insured/ claimant(s), do solemnly declare that the foregoing answers and statements are true in all respects, and further agree that the furnishing of this form, or any other form supplemental thereto, to the Company, shall not constitute an admission by the Company that there was any insurance in force on the life in question or a waiver of any rights or defense. Notwithstanding, any law, custom or usage, prohibiting the furnishing of secret information obtained during the medical treatment / investigation of Life Insured,

I/We hereby authorize any doctor or other person, or any hospital, sanatorium, medical professional, hospital or other medical care institution, insurance support organization, pharmacy, governmental agency, insurance company, employer, benefit plan administrator, accountant, or financial adviser or other institute to provide to SBI LIFE INSURANCE COMPANY LTD, any of its offices, or Court of Law, or any investigative agency or independent administrator acting on its behalf, information concerning employment, finances or insurance, advice, care or treatment provided to Insured, or any information that may be required concerning the health of the Insured including information relating to mental illness, use of drugs, use of alcohol, HIV(AIDS Virus) and /or sexually transmitted diseases. A Photostat copy of this authorization shall be considered as effective and valid as the original.

Signature / Thumb Impression of Life Insured

_____

Place _____

Date _____

In case the Life assured is unable to sign/ is a minor: Signature of Primary life assured/ Proposer/ Nominee

Name:_____

Place _____

Date _____

PLEASE PROVIDE THE FOLLOWING DETAILS OF THE CLAIMANT

Name of Claimant: _____

Status: Primary Life Assured ☐ Proposer ☐ Nominee ☐

Date of Birth: dd/mm/yyyy

Address: _____

_____

_____

City:_____State_____

Tel No: _____Place: _____

The claim form along with the aforereferred documents should be sent to the following address

E-Meditek (TPA) Services Limited- Claims department

208/209 Turf Estate,

Off Dr.E.Moses Marg,

Beside Mahalakshmi Satation, Mahalakshmi

Mumbai, Toll free number - 1800 102 3242

AGE PROOF*	
Standard Age proof	a) Birth Certificate issued by the Municipal authorities b) School / College Certificate, Board / University admit card / marks sheet, Transfer certificate issued by the school / college in a authorized format duly signed and sealed; It is mandatory that School / College certificates bear name and address of School / College and registration / admission number and date of registration / admission along with name and father's name of the life to be assured c) Passport d) Service Extract in case of Central Govt. / State Govt. / Municipal / PSU / Reputed organizations and companies e) Baptism Certificate / Marriage Certificate in case of Roman Catholics f) Defense ID card g) Domicile Certificate h) Gram Panchayat Certificate :should be an extract from the register of Gram Panchayat with the serial number of the record on the register appearing thereon i) Valid Driving License j) PAN Card k) Provident Fund Statement issued by the Employer in case of PSU employees l) Pension Order of self m) Employee Identity Card (bearing DOB) issued by Central Govt. / State Govt. / Municipal authorities / PSU / Reputed private Company for their employees