FORM 2: CLAIM FORM

IFFCO TOKIO GENERAL INSURANCE COMPANY LIMITED

IFFCO-TOKIO

Muskurate Raho

CLAIM FORM - PART A (TO BE FILLED IN BY INSURED)

INSURANCE DETAILS					
Policy No		SNo/ Certificate No:			
Company/ TPA ID No		Name of Proposer			
Address of Proposer (Primary Insured)					
Name of Claimant					
Relation to proposer		Date of Birth		Age	
Address					
Gender	Male / Female	Occupation			
Telephone No		Mobile No			
E-mail ID, if any					
Insurance History	Date of commencement of first Insurance for the person				
Are you presently covered with any other Mediclaim / Health Insurance?			Y/N		
If Y, give details - Company / Policy No / Sum Insured (Attach Policy copies)					
Primary Insured's Bank Account particulars		PAN No.			
Account Number		Bank Name			
Branch		IFSC Code			

HOSPITALIZATION DETAILS					
Name of the Hospital where admitted					
Room Type-Day care / Single / Twin sharing etc...					
Past Hospitalisation	Y/N	Month and Yr		DIAGNOSIS:	
Hospitallisation due to: Illness / Injury / Maternity		Details			
Date of Injury / Disease first detected / LMP					
If injury, how it occurred					
If injury, whether Medico legal	Y/N	If MLC, reported to police?		Y/N (Enclose MLC /FIR)	
Is claim is for **Domiciliary Hospitalisation?**		Y/N (If Y, provide details in annexur			

EXPENSES AND BILLING DETAILS			
Pre-hospitalisation Expenses	Rs.	Hospitalisation Expenses	Rs.
Post-hospitalisation Expenses	Rs.	Health-Check up Cost	Rs.
Ambulance Charges	Rs.	Others	Rs.
Details of Lumpsum / cash benefit claimed:			
Hospital Daily Cash	Surgical Cash		Critical Illness benefit
Convalescence:	Pre / Post hosp lumpsum benefit:		Others

Details of bills enclosed (attach separate sheet, if space inadequate)

Sl.	Bill No	Date	Issued By	Towards	Amount

Details of Claim Documents submitted - CHECK LIST						
Claim Form Duly signed		Y	N	Pre-hosp Bills: _____ Nos	Y	N
Copy of the claim intimation		Y	N	Post-hosp Bills: _____ Nos	Y	N
Hospital Discharge Summary		Y	N	Investigation Reports	Y	N
Operation Theatre Notes		Y	N	Doctor request for investigation	Y	N
Hospital Main Bill		Y	N	ECG	Y	N
Hospital Break-up Bill		Y	N	Pharmacy Bills	Y	N
Hospital Bill Payment Receipt		Y	N	MLC Report & Police FIR	Y	N
Doctor\s Prescriptions		Y	N	Any other, please specify	Y	N

Date: Signature of the Primary Insured / Claimant