

5 easy ways to speed up the claims process

1

Submit all original documents as per the checklist within 60 days of date of diagnosis or occurrence of event.

2

Make sure the form is complete and don't forget to sign.

3

Provide correct and accurate bank details.

4

For any assistance, please reach out to your health advisor or connect with our Health Relationship Manager.

5

Do not conceal or withhold any information with respect to your claim.

MANIPALCIGNA LIFESTYLE PROTECTION - CRITICAL CARE CLAIM FORM

SECTION A: DETAILS OF PRIMARY INSURED:

a) Policy No.:	<input type="text"/>	b) Sl. No. / Certificate No.:	<input type="text"/>
c) Company/TPA ID:	<input type="text"/>		
d) Name:	<input type="text"/>		
e) Address:	<input type="text"/>		
	<input type="text"/>		
City:	<input type="text"/>	State:	<input type="text"/>
		Pin Code:	<input type="text"/>
f) Phone No.:	<input type="text"/>		
g) E-mail ID:	<input type="text"/>		

SECTION B: DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediciam / Health Insurance:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b) Date of Commencement of First Insurance without Break:	<input type="text"/>	
c) If yes, Company Name:	<input type="text"/>	
Policy No.:	<input type="text"/>	Sum Insured (₹): <input type="text"/>
d) Have you been hospitalised in the last four years since inception of the contract?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diagnosis:	<input type="text"/>	
e) Previously covered by any other Mediciam / Health Insurance :	Yes <input type="checkbox"/>	No <input type="checkbox"/>
f) If yes, Company Name:	<input type="text"/>	

SECTION C: DETAILS OF INSURED PERSON HOSPITALISED:

a) Name:	<input type="text"/>		
b) Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Others <input type="checkbox"/>
c) Age: Years	<input type="text"/>	Months	<input type="text"/>
d) Date of Birth:	<input type="text"/>		
e) Relationship to Primary Insured:	Self <input type="checkbox"/>	Spouse <input type="checkbox"/>	Child <input type="checkbox"/>
	Father <input type="checkbox"/>	Mother <input type="checkbox"/>	Other (Please Specify) <input type="text"/>
f) Occupation:	Service <input type="checkbox"/>	Self Employed <input type="checkbox"/>	Homemaker <input type="checkbox"/>
	Student <input type="checkbox"/>	Retired <input type="checkbox"/>	Other (Please Specify) <input type="text"/>
g) Address:	<input type="text"/>		
(If different from above)	<input type="text"/>		
City:	<input type="text"/>	State:	<input type="text"/>
		Pin Code:	<input type="text"/>
Phone No.:	<input type="text"/>		
E-mail ID:	<input type="text"/>		

SECTION D: DETAILS OF HOSPITALISATION:

a) Name of Hospital where Admitted:

b) Room Category Occupied: Day Care ☐ Single Occupancy ☐ Twin Sharing ☐
3 or more Beds per Room ☐

c) Hospitalisation due to: Injury ☐ Illness ☐ Maternity ☐

d) Date of Injury / Date Disease first detected / Date of Delivery:

e) Date of Admission:

f) Time: :

g) Date of Discharge:

h) Time: :

i) If Injury, give Cause: Self Inflicted ☐ Road Traffic Accident ☐ Substance Abuse / Alcohol Consumption ☐

ii. If Medico Legal: Yes ☐ No ☐ iii. Reported to Police: Yes ☐ No ☐ iii. MLC Report & Police FIR attached: Yes ☐ No ☐

j) System of Medicine:

SECTION E: DETAILS OF CLAIM:

a) Details of the Treatment Expenses claimed:

i. Pre-hospitalisation Expenses: ₹

ii. Hospitalisation Expenses: ₹

iii. Post-hospitalisation Expenses: ₹

iv. Health-Check up Cost: ₹

v. Ambulance Charges: ₹

vi. Others: ₹

TOTAL ₹

vii. Pre-hospitalization Period: Days

viii. Post-hospitalisation Period: Days

b) Claim for Domiciliary Hospitalisation: Yes ☐ No ☐

c) Details of Lump Sum / Cash Benefit claimed:

i. Hospital Daily Cash: ₹

ii. Surgical Cost: ₹

iii. Critical Illness Benefit: ₹

iii.a Please tick against the Critical Illness that the Insured Person has been diagnosed with

1. Cancer of specific severity	<input type="checkbox"/>	2. First Heart Attack - of Specific Severity	<input type="checkbox"/>
3. Open Chest CABG	<input type="checkbox"/>	4. Open Heart Replacement or Repair of Heart Valves	<input type="checkbox"/>
5. Coma of Specified Severity	<input type="checkbox"/>	6. Kidney Failure Requiring Regular Dialysis	<input type="checkbox"/>
7. Stroke Resulting in Permanent Symptoms	<input type="checkbox"/>	8. Major Organ / Bone Marrow Transplant	<input type="checkbox"/>
9. Permanent Paralysis of Limbs	<input type="checkbox"/>	10. Motor Neurone Disease with Permanent Symptoms	<input type="checkbox"/>
11. Multiple Sclerosis with Persisting Symptoms	<input type="checkbox"/>	12. Primary Pulmonary Hypertension	<input type="checkbox"/>
13. Aorta Graft Surgery	<input type="checkbox"/>	14. Loss of Hearing	<input type="checkbox"/>
15. Loss of Sight	<input type="checkbox"/>	16. Coronary Artery Disease	<input type="checkbox"/>
17. Aplastic Anaemia	<input type="checkbox"/>	18. End Stage Lung Disease	<input type="checkbox"/>
19. End Stage Liver Failure	<input type="checkbox"/>	20. Major Burns	<input type="checkbox"/>
21. Fulminant Hepatitis	<input type="checkbox"/>	22. Alzheimer's Disease	<input type="checkbox"/>
23. Bacterial Meningitis	<input type="checkbox"/>	24. Benign Brain Tumor	<input type="checkbox"/>
25. Apallie Syndrome	<input type="checkbox"/>	26. Parkinsons Disease	<input type="checkbox"/>
27. Medullary Cystic Disease	<input type="checkbox"/>	28. Muscular Dystrophy	<input type="checkbox"/>
29. Loss of Speech	<input type="checkbox"/>	30. Systemic Lupus Erythematosus	<input type="checkbox"/>

iii.b Medical Second Opinion: Yes ☐ No ☐

iii.c Only applicable for members who have Opted for 'Staggered Pay-out for Critical Illness'

Do you wish to Obtain Lumpsum payout and nullify the Staggered payout Option: Yes ☐ No ☐

iv. Convalescence: ₹

v. Pre / Post Hospitalisation: ₹

vi. Lumpsum Benefit: ₹

vii. Others: ₹

TOTAL ₹

- ☐ Claim Form Duly signed
- ☐ Hospital Main Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Pharmacy Bills
- ☐ ECG
- ☐ Investigation Reports (Including CT/MRI/USG/HPE)
- ☐ Others

- ☐ Copy of the claim Intimation, if any
- ☐ Hospital Break-up Bill
- ☐ Hospital Discharge Summary
- ☐ Operation Theatre Notes
- ☐ Doctor's request for investigation
- ☐ Doctors Prescriptions

Sl. No.	Bill No.	Date	Issued By	Towards	Amount (₹)
1.		<input type="text"/>		Hospital Main Bill	
2.		<input type="text"/>		Pre-hospitalisation Bills: Nos.	
3.		<input type="text"/>		Post-hospitalisation Bills: Nos.	
4.		<input type="text"/>		Pharmacy Bills	
5.		<input type="text"/>			
6.		<input type="text"/>			
7.		<input type="text"/>			
8.		<input type="text"/>			
9.		<input type="text"/>			
10.		<input type="text"/>			
				Total Claimed Amount	

[illegible]**SECTION H: DECLARATION BY THE INSURED:**

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorise TPA / insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre / post-hospitalisation claim, if any.

Date: DD MM YY YY

Place:

Signature of the Insured:

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured):

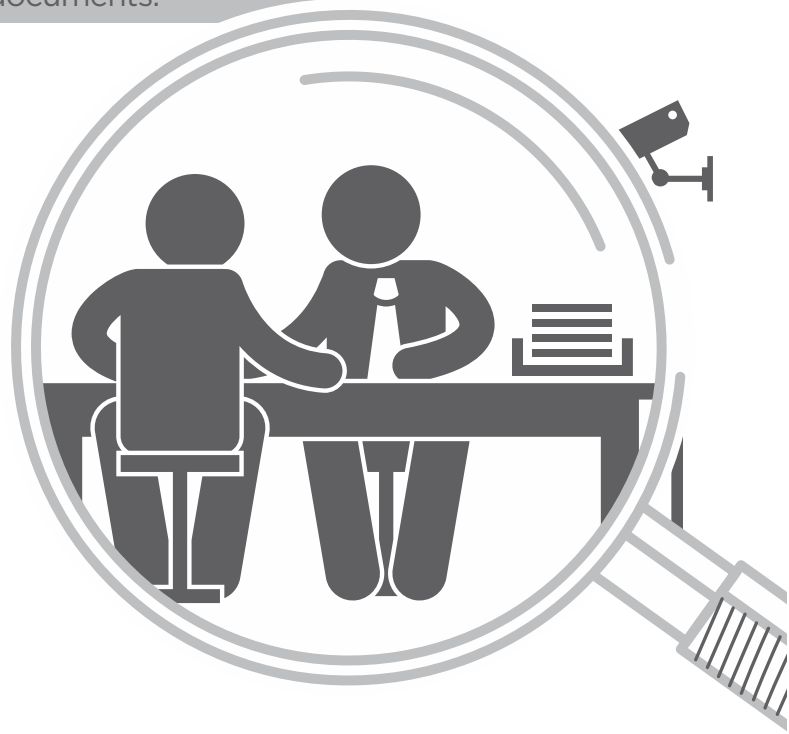
DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the Policy Number	As allotted by the Insurance Company
b) SI. No. / Certificate No.	Enter the Social Insurance Number or the Certificate Number of Social Health Insurance Scheme	As allotted by the Organisation
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents
d) Name	Enter the full name of the Policyholder	Surname, First name, Middle name
e) Address	Enter the full Postal Address	Include Street, City and Pin Code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of Commencement of First Insurance without Break	Enter the Date of Commencement of First Insurance	Use dd-mm-yy format
c) Company Name	Enter the Full Name of the Insurance Company	Name of the Organization in full
Policy No.	Enter the Policy Number	As allotted by the Insurance Company
Sum Insured	Enter the Total Sum Insured as per the Policy	In Rupees
d) Have you been Hospitalised in the Last Four Years since Inception	Indicate whether Hospitalised in the Last Four Years of the Contract?	Tick Yes or No
Date	Enter the Date of Hospitalisation	Use mm-yy format
Diagnosis	Enter the Diagnosis Details	Open Text
e) Previously covered by any other Mediclaim / Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the Full Name of the Insurance Company	Name of the Organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALISED		
a) Name	Enter the Full Name of the Patient	Surname, First Name, Middle Name
b) Gender	Indicate Gender of the Patient	Tick Male, Female or Others
c) Age	Enter Age of the Patient	Number of Years and Months
d) Date of Birth	Enter Date of Birth of Patient	Use dd-mm-yy format
e) Relationship to Primary Insured	Indicate Relationship of Patient with Policyholder	Tick the right option. If others, please specify.
f) Occupation	Indicate Occupation of Patient	Tick the right option. If others, please specify.
g) Address	Enter the Full Postal Address	Include Street, City and Pin Code
h) Phone No.	Enter the Phone Number of Patient	Include STD code with telephone number
i) E-mail ID	Enter E-mail Address of Patient	Complete E-mail Address
SECTION D - DETAILS OF HOSPITALISATION		
a) Name of Hospital where Admitted	Enter the Name of Hospital	Name of Hospital in full
b) Room Category Occupied	Indicate the Room Category Occupied	Tick the right option
c) Hospitalisation due to	Indicate Reason of Hospitalisation	Tick the right option
d) Date of Injury / Date Disease First Detected / Date of Delivery	Enter the Relevant Date	Use dd-mm-yy format
e) Date of Admission	Enter Date of Admission	Use dd-mm-yy format
f) Time	Enter Time of Admission	Use hh:mm format
g) Date of Discharge	Enter Date of Discharge	Use dd-mm-yy format
h) Time	Enter Time of Discharge	Use hh:mm format
i) If Injury, give cause	Indicate Cause of Injury	Tick the right option
If Medico Legal	Indicate whether Injury is Medico Legal	Tick Yes or No
Reported to Police	Indicate whether Police Report was filed	Tick Yes or No
MLC Report & Police FIR attached	Indicate whether MLC Report and Police FIR attached	Tick Yes or No
j) System of Medicine	Enter the System of Medicine followed in treating the Patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the Amount claimed as Treatment Expenses	In Rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalisation	Indicate whether Claim is for Domiciliary Hospitalisation	Tick Yes or No
c) Details of Lump Sum / Cash Benefit claimed	Enter the Amount claimed as Lump Sum / Cash Benefit	In Rupees (Do not enter paise values)
d) Claim Documents Submitted - Check List	Indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the Amounts in Rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the Permanent Account Number	As allotted by the Income Tax Department
b) Account Number	Enter the Bank Account Number	As allotted by the Bank
c) Bank Name and Branch	Enter the Bank Name along with the Branch	Name of the Bank in full
d) Cheque / DD Payable Details	Enter the Name of the Beneficiary, the Cheque / DD should be made out to	Name of the Individual / Organisation in full
e) IFSC Code	Enter the IFSC Code of the Bank Branch	IFSC Code of the Bank Branch in full
SECTION H - DECLARATION BY THE INSURED		
Read Declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

Know Your Customer

Processing your claim smoothly and quickly is of importance to you as well as us. Help us remain as your trusted service partner by ensuring we have a copy of all your documents.

Mandatory KYC documents required

- Original cancelled Cheque with pre-printed name of the proposer
- For claims over 1 lakh
 - Color passport size photograph not older than 6 months
 - Copy of PAN card
 - Copy of address proof



Proof of Residence (Any one of below mentioned documents required)

- Driving license / Adhaar card
- Electricity bill / Ration card*
- Letter from any recognised public authority
- Current statement of bank account with details of permanent/ present residence address as stamped by bank*
- Current passbook with details of permanent/ present residence address (updated up to the previous month)*
- Valid lease agreement along with rent receipt, which is not more than three months old as a residence proof
- Telephone bill pertaining to any kind of telephone connection like, mobile, landline, wireless, etc. provided it is not older than six months from the date of insurance contract
- Employer's certificate as a proof of residence (Certificates of employers who have in place systematic procedures for recruitment along with maintenance of mandatory records of its employees are generally reliable)

*Acceptable as Address proof and Identity proof if photograph of applicant is affixed