ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited)
OR Nearest ManipalCigna Branch.
Registered & Corporate Office: 401/402, Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063.
IRDAI Registration No. 151**. Call** (Toll Free): 1800-102-4462 **Visit:** www.manipalcigna.com **E-mail:** servicesupport@manipalcigna.com

ManipalCigna Health Insurance

The issue of this Form is not to be taken as an admission of liability
(To be filled in Block Letters) - PART A - To be filled by Insured

5 easy ways to speed up the claims process

1. Submit all original documents as per the checklist within 30 days of occurrence of event.
2. Make sure the form is complete and don't forget to sign.
3. Provide correct and accurate bank details with Cancelled cheque
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 GROUP POLICY
GROUP PERSONAL ACCIDENT OPTIONAL COVERS CLAIM FORM

Please submit this claim form along with Group Personal Accident Base Covers Claim Form

SECTION I- TO BE COMPLETED BY INSURED PERSON

A. DETAILS OF INSURED PERSON IN RESPECT OF WHOM CLAIM IS MADE:

a) Corporate Name: b) Policy No.:

c) Name: FIRST NAME MIDDLE NAME LAST NAME

d) Address:

City: State: Pin Code:

e) Date of Birth: DD MM YYYY f) Occupation:

g) Phone No.: h) Mobile No.:

I) E-mail ID:

B. DETAILS OF OPTIONAL COVERS CLAIMED:

	Benefit	Amount
1	Disappearance Benefit	
2	Broken Bones Benefit	
3	Burns Benefit	
4	Coma Benefit	
5	Accidental Death Benefit (Common Carrier)	
6	Permanent Total Disablement Benefit (Common Carrier)	
7	Permanent Total Disablement Double Benefit	
8	Cost of Support Items Benefit	
9	Modification allowance benefit	
10	Rehabilitation Benefit	
11	Animal Attack Benefit	
12	Cost of Personal Protective Equipment (PPE) Damaged in the Accident Benefit	
13	Funeral Expenses Benefit	
14	Emergency Road Ambulance Benefit	
15	Repatriation of Mortal Remains Benefit	
16	Dependent Children Benefit	
17	Widow Benefit	
18	Dependant Parent Benefit	
19	Marriage Benefit for Dependent Children	

ManipalCigna Lifestyle Protection Group Policy | UIN: MCIPAGP21235V032021 | September 2020

	Benefit	Amount
☐	20 Education Fund Benefit	
☐	21 Retraining Expenses Benefit	
☐	22 Convalescence Benefit	
☐	23 Hospital Cash Benefit	
☐	24 Loss of Earning Benefit	
☐	25 Family Counseling Benefit	
☐	26 Family Transportation Allowance Benefit	
☐	27 Medical Second Opinion	
☐	28 Wellness Benefit	
☐	29 Accidental Medical Expenses	
☐	30 Out Patient Benefit	
☐	31 In- Patient Medical Expenses	
☐	32 Emergency Evacuation	
☐	33 Medical Repatriation	
☐	34 Adventure Sports Benefit	

C. DETAILS OF THE INSURED IN RESPECT OF OPTIONAL COVERS (to be filled by claimant wherever applicable):

☐ **1 Disappearance Benefit**

a. Date of Disappearance: D D M M Y Y Y Y

b. Place of Disappearance:

c. Details of the event: _____

d. Whether reported to Police: Yes ☐ No ☐

If Yes, Name and Address of Police Station: _____

e. If No, Give reasons: _____

f. First Information Report (FIR)/ Missing complaint Number and Date: D D M M Y Y Y Y

g. Contact Details of Police Station: _____

h. Has a suit being filed for Legal Assumption of Death? Yes ☐ No ☐

If Yes, please provide details: _____

☐ **2 Broken Bones Benefit**

a. Place of Accident/Injury:

b. Details of Accident and Nature of Accident: _____

☐ **3 Burns Benefit**

a. Place of Accident/Injury:

b. Details of Accident and Nature of Accident: _____

☐ **4 Coma Benefit**

a. Place of Accident/Injury:

b. Details of Accident and Nature of Accident: _____

☐ **5 Accidental Death Benefit (Common Carrier)**

a. Place of Accident/Injury:

b. Details of Accident and Nature of Accident:

c. Date of Travel: D D M M Y Y Y Y

d. Mode of Travel:

e. Travel From: D D M M Y Y Y Y To: D D M M Y Y Y Y

☐ **6 Permanent Total Disablement Benefit (Common Carrier)**

a. Place of Accident/Injury:

b. Details of Accident and Nature of Accident:

c. Date of Travel: D D M M Y Y Y Y

d. Mode of Travel:

e. Travel From: D D M M Y Y Y Y To: D D M M Y Y Y Y

☐ **7 Permanent Total Disablement Double Benefit**

a. Place of Accident/Injury:

b. Details of Accident and Nature of Accident:

☐ **8 Cost of Support Items Benefit**

a. Type of support items prescribed:

Cost incurred:

b. Additional items prescribed:

Cost incurred:

c. Chauffer/ Taxi Services availed to D D M M Y Y Y Y from D D M M Y Y Y Y

Cost incurred:

d. Domestic Helper Services availed from D D M M Y Y Y Y

Cost incurred:

☐ **9 Modification allowance benefit**

a. Modification done for : Home ☐ Car ☐

b. Type of modification done:

Cost incurred:

☐ **10 Rehabilitation Benefit**

a. Services availed: Specialist Consultation ☐ Extended Physiotherapy ☐

b. Cost incurred:

☐ **11 Animal Attack Benefit**

a. Type of animal:

b. Place of Accident/Injury:

c. Details of Accident:

d. Details of Treatment availed:

e. Cost incurred:

☐ **12 Cost of Personal Protective Equipment (PPE) Damaged in the Accident Benefit**

a. Details of PPE that are damaged:

b. Cost incurred:

☐ **13 Funeral Expenses Benefit**

a. Costs incurred for Funeral:

☐ **14 Emergency Road Ambulance Benefit**

a. Ambulance Charges:

☐ **15 Repatriation of Mortal Remains Benefit**

a. Location from which the repatriation has to be conducted:

b. Location to which the repatriation has to be conducted:

☐ **16 Dependent Children Benefit**

a. No of Children:

b. Date of Birth of Child/ Children: D D M M Y Y Y Y D D M M Y Y Y Y

☐ **17 Widow Benefit**

a. Name of Spouse:

☐ **18 Dependant Parent Benefit**

a. Name of Parent:

b. Occupation of Parent:

☐ **19 Marriage Benefit for Dependent Children**

a. No of Children:

b. Date of Birth of Child/ Children: D D M M Y Y Y Y D D M M Y Y Y Y

☐ **20 Education Fund Benefit**

a. Name of Child/ Children:

b. Tuition Fees paid for the current academic year:

☐ **21 Retraining Expenses Benefit**

a. Details of expense incurred for retraining:

☐ **22 Convalescence Benefit**

a. Date of hospitalisation: D D M M Y Y Y Y b. Date of Discharge: D D M M Y Y Y Y

c. Diagnosis as per Discharge card:

☐ **23 Hospital Cash Benefit**

a. Date of hospitalisation: D D M M Y Y Y Y b. Date of Discharge: D D M M Y Y Y Y

c. Diagnosis as per Discharge card

☐ **24 Loss of Earning Benefit**

a. Total monthly income last drawn:

☐ **25 Family Counseling Benefit**

a. Details of prescribed Counseling:

b. Expense incurred for Counseling:

☐ **26 Family Transportation Allowance Benefit**

a. Travelled: From D D M M Y Y Y Y To D D M M Y Y Y Y

b. Mode of Transport:

c. Expenses incurred for Travelling:

☐ **27 Medical Second Opinion**

a. Place of Accident/Injury:

b. Details of Accident and Nature of Accident:

c. Current Diagnosis:

☐ **28 Wellness Benefit**

a. Expenses incurred for Diagnostic Test: _____

☐ **29 Accidental Medical Expenses**

a. Date of hospitalisation: D D M M Y Y Y Y b. Date of Discharge: D D M M Y Y Y Y

c. Diagnosis as per Discharge card: _____

Group Indemnity Hospitalisation Claim Form to be filled in addition to above.

☐ **30 Out Patient Benefit**

a. Date of consultation: D D M M Y Y Y Y

b. Diagnosis: _____

Group Indemnity Hospitalisation Claim Form to be filled in addition to above.

☐ **31 In- Patient Medical Expenses**

a. Date of hospitalisation: D D M M Y Y Y Y b. Date of Discharge: D D M M Y Y Y Y

c. Diagnosis as per Discharge card: _____

Group Indemnity Hospitalisation Claim Form to be filled in addition to above.

☐ **32 Emergency Evacuation**

a. Location from which evacuation has to be conducted: _____

b. Location to which evacuation has to be conducted: _____

☐ **33 Medical Repatriation**

a. Location from which repatriation has to be conducted: _____

b. Location to which repatriation has to be conducted: _____

☐ **34 Adventure Sports Benefit**

Type of Adventure Sport

a. Place of Accident/Injury:

b. Details of Accident: _____

c. Details of Treatment availed: _____

d. Cost incurred:

D. CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM: (In addition to the documents listed under specific section of Base Covers Opted)

☐ Disappearance Benefit	FIR/ Missing complaint Confirmation of Death/Certificate of Death (legal assumption) post completion of relevant period applicable under law
☐ Broken Bones Benefit	X-Ray/MRI/CT-Scan/Radiology Films/Reports confirming the extent of fracture
☐ Burns Benefit	Certificate from the treating doctor certifying the extent of burns injury
☐ Coma Benefit	Certificate from the treating doctor certifying the cause and severity of Coma
☐ Accidental Death Benefit (Common Carrier) ☐ Permanent Total Disablement Benefit (Common Carrier)	Original Passenger Ticket / Boarding Pass issued in the name of the Insured Person from the Common Carrier (in case of death in a common carrier).Wherever a named ticket is not available, onus of proof of travel will be upon the Insured Person
☐ Permanent Total Disablement Double Benefit	List of documents same as Permanent Total Disablement Benefit
☐ Cost of Support Items Benefit	Prescriptions of treating Medical Specialist for support items and Original invoice of actual expenses incurred
☐ Modification allowance benefit	Original invoice of actual expenses incurred
☐ Rehabilitation Benefit	Original invoice of counseling by a professional counselor/ Physiotherapist
☐ Animal Attack Benefit	Original copies of Hospital/ OPD bills, receipts, prescriptions and invoices

☐ Cost of Personal Protective Equipment (PPE) Damaged in the Accident Benefit	Original invoices of incurred expenses towards replacement of Personal Protective Equipment
☐ Funeral Expenses Benefit	Original invoice of expenses incurred during funeral
☐ Emergency Road Ambulance Benefit	Original invoice of actual expenses incurred towards Ambulance
☐ Dependent Children Benefit	Proof of relationship with the Insured and Age proof of the dependent child
☐ Widow Benefit	Proof of relationship with the Insured
☐ Dependant Parent Benefit	Proof of relationship with the Insured and Last ITR of the dependent parent
☐ Marriage Benefit for Dependent Children	Proof of relationship with the Insured and Age proof of the dependent child
☐ Education Fund Benefit	Proof of expenses incurred towards tuition fees as a full time student at an accredited educational institution and Age proof of the dependent child.
☐ Retraining Expenses Benefit	Original invoices of incurred expenses towards re-training
☐ Convalescence Benefit ☐ Hospital Cash Benefit	Original copies of Hospital bills, receipts, prescriptions and invoices
☐ Loss of Earning Benefit	In case of salaried Insured Persons, Last 3 month's salary slips of the previous employer of the Insured Person In case of self-employed Insured Persons, Last income tax returns filed by the Insured Person with the income tax department
☐ Family Counseling Benefit	Original invoice of counseling by a professional counselor
☐ Family Transportation Allowance Benefit	Original invoice of travel expense incurred
☐ Accidental Medical Expenses ☐ Out Patient Treatment Allowance ☐ In- Patient Medical Expenses Benefit	Original copies of Consultations, Hospital bills, receipts, investigation reports & bills, prescriptions and invoices
☐ Adventure Sports Benefit	Same list of documents like Accidental Death or Permanent Total Disablement

E. 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 & authorize 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.

Date: D D M M Y Y Y Y Place: Signature of the Insured:

SECTION II: TO BE FILLED BY TREATING DOCTOR WHO ATTENDED THE INSURED

1) In case of Broken Bone Benefit:

a. Has the accident/injury resulted in broken bones/fracture as a direct result of the present injury? **Yes** ☐ **No** ☐

If Yes, please provide the type and nature of fractured bone: _____

_____

b. Is this fracture, result of any illness/disease/malignancy/osteoporosis? Yes No

If Yes, please provide details: _____

_____

2) In case of Burns Benefit:

a. Nature and Extent of Burns Injury: _____

b. Percentage of surface area of Burns: _____

3) In case of Coma Benefit:

a. Please specify the cause and severity of coma: _____

b. Are life support measures necessary to sustain life: _____

c. Extent of neurological deficit: _____

I hereby state that I have treated the Patient in connection with the above condition and that the facts as given above are correct to the best of my knowledge.

Name of the Doctor:

Registration Number:

Qualification: Specialization:

Address: _____

_____

Contact Number:

Date: D D M M Y Y Y Y

Place:

Signature and Seal of the Hospital Authority:

GUIDANCE FOR FILLING CLAIM FORM -(To be filled in by the Insured/ claimant)

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION I- TO BE COMPLETED BY INSURED PERSON		
A. Details of Policy Holder:		
a. Name of Corporate	Enter the company name	Free Text
b. Policy Number	Enter the policy number	As allotted by the insurance company
c. Name of Policy Holder	Enter the Full Name of the Policy Holder	First Name, Middle Name, Surname
d. Address	Enter the Full Postal Address	Include Street, City, State and Pin Code
e. Date of Birth (DD/MM/YYYY)	Enter Date of Birth of Policyholder	Use DD/MM/YYYY format
f. Occupation	Indicate Occupation of Policy Holder	Please specify the Occupation
g. Telephone Number	Enter the Phone Number of Policyholder	Include STD code with telephone number
h. Mobile No	Enter the Mobile Number of Policyholder	Please enter a 10 digit number
i. Email	Enter E-mail Address of Policyholder	Complete E-mail Address
B. Details of Optional Covers Claimed:		
Please Indicate and Tick the Benefits claimed		
C. Details of the Insured in respect of Optional Covers		
Please indicate claim details against each of the availed optional covers		
D. Check List of Enclosures for Submission of Claim		
Please indicate against the checklist for availed optional covers		
E. Declaration by the Insured		
Read Declaration carefully and mention date (in DD/MM/YYYY format), place (open text) and sign.		