

Please return your completed claim form to:

**ManipalCigna Health Insurance Company Limited** (Formerly known as CignaTTK Health Insurance Company Limited)

OR Nearest ManipalCigna Branch.

**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:** customercare@manipalcigna.com

The issue of this Form is not to be taken as an admission of liability

(To be filled in Block Letters) - PART I - To be filled by Insured



## SARAL SURAKSHA BIMA, MANIPALCIGNA CLAIM FORM

### PART I - TO BE COMPLETED BY INSURED PERSON

#### SECTION A - DETAILS OF POLICY HOLDER

a) Policy No:	<input type="text"/>
b) Name of Policy Holder:	<input type="text"/> F I R S T N A M E <input type="text"/> M I D D L E N A M E <input type="text"/> S U R N A M E
c) Address:	<input type="text"/> <input type="text"/>
City:	<input type="text"/>
State:	<input type="text"/>
Pin Code:	<input type="text"/>
d) Date of Birth (DD/MM/YYYY):	<input type="text"/> D D <input type="text"/> M M <input type="text"/> Y Y Y Y
e) Occupation:	<input type="text"/>
f) Telephone Number:	<input type="text"/>
g) Mobile No:	<input type="text"/>
h) Email:	<input type="text"/>

#### SECTION B - DETAILS OF THE INSURED IN RESPECT OF WHOM CLAIM IS MADE

a) Name of Insured Person:	<input type="text"/> F I R S T N A M E <input type="text"/> M I D D L E N A M E <input type="text"/> S U R N A M E
b) Address:	<input type="text"/> <input type="text"/>
City:	<input type="text"/>
State:	<input type="text"/>
Pin Code:	<input type="text"/>
c) Date of Birth (DD/MM/YYYY):	<input type="text"/> D D <input type="text"/> M M <input type="text"/> Y Y Y Y
d) Occupation:	<input type="text"/>
e) Telephone Number:	<input type="text"/>
f) Mobile No:	<input type="text"/>
g) Email:	<input type="text"/>
h) Relationship with Policy Holder:	<input type="text"/>
i) Date (DD/MM/YYYY) and Time of Injury/Death:	<input type="text"/> D D <input type="text"/> M M <input type="text"/> Y Y Y Y <input type="text"/> : <input type="text"/>
j) Place of Accident/ Injury/ Death:	<input type="text"/>
k) Details and Nature of Accident:	<input type="text"/> <input type="text"/> <input type="text"/>
l) Did the Accident happen when you were working:	Yes <input type="checkbox"/> No <input type="checkbox"/>
m) If Yes, Name and Address of Employer:	<input type="text"/> <input type="text"/> <input type="text"/>
n) Whether reported to Police:	Yes <input type="checkbox"/> No <input type="checkbox"/>
o) If Yes, Name and Address of Police Station:	<input type="text"/> <input type="text"/>
p) If No, Give reasons:	<input type="text"/>
q) First Information Report (FIR) Number and Date:	<input type="text"/> <input type="text"/> D D <input type="text"/> M M <input type="text"/> Y Y Y Y
r) Contact Details of Police Station:	<input type="text"/>

### SECTION C - DETAILS OF HOSPITALIZATION IMMEDIATELY AFTER THE ACCIDENT

Yes  No  (If Yes, please give the following)

a) Name of the Hospital:

b) Address of Hospital:

c) Date of Admission:

d) Date of Discharge:

### SECTION D - DETAILS OF WITNESSES

a) Was there any witness to the event: Yes  No  (If Yes, complete the following)

b) Name:

c) Address:

City:  State:  Pin Code:

Place of Witness:

d) Phone Number (Home):  e) Phone Number (Mobile):

f) Phone Number (Work):

### SECTION E - DETAILS OF ANY OTHER PERSONAL ACCIDENT POLICY

Yes  No  (If Yes, complete the following)

a) Name of the Insurer:

b) Address of the Issuing office:

City:  State:  Pin Code:

c) Policy Number:

d) Policy Period:  e) Sum Insured:

### SECTION F - DETAILS OF BENEFITS CLAIMED

Accidental Death  Permanent Total Disablement

Permanent Partial Disablement  Temporary Total Disablement

Education Grant  Hospitalization Expenses due to Accident

### SECTION G - CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

#### Documents Required for All claims:

Photo Identity Proof - Voter ID, Passport, PAN Card, Driving License, Ration Card, Aadhar, or any other proof accepted by the KYC norms as approved by the Company and which is admissible in court of law

Duly completed and signed claim form in original as prescribed by Us.

Copy of FIR/ Panchnama /Police Inquest Report (if conducted) duly attested by the concerned Police Station;

Copy of Medico Legal Certificate(if conducted) duly attested by the concerned Hospital,

Income Proof

- Last 3 months Salary Slip/Form 16 for salaried persons

- Last financial years ITR for self-employed persons





**PART IV: TO BE FILLED BY EMPLOYER (IN CASE, INSURED IS EMPLOYED)**

1. Name of the Company: \_\_\_\_\_

2. Address & Contact Details of the Company \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Name of the Employee: \_\_\_\_\_

4. Date of Joining Service:  Designation: \_\_\_\_\_

5. Please provide details of the leave availed by the employee, specifying the type of leave.

Sr. No	Date from which leave is taken	Date when resumed duties	No. of Days	Type of Leave	In case of Sickness Leave, medical certificate produced- Yes/ No	Reason for Leave

Signature and Seal of the authorized signatory of the Company:

Name of the Authorised Signatory: \_\_\_\_\_

Designation: \_\_\_\_\_

Date:

Place:

Signature and Seal:

**GUIDANCE FOR FILLING CLAIM FORM - PART A (TO BE FILLED IN BY THE INSURED)**

DATA ELEMENT	DESCRIPTION	FORMAT
<b>SECTION A - DETAILS OF POLICYHOLDER</b>		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) Name of Policy Holder	Enter the Full Name of the Patient	First Name, Middle Name, Surname
c) Address	Enter the Full Postal Address	Include Street, City, State and Pin Code
d) Date of Birth	Enter Date of Birth of Policyholder	Use DD/MM/YYYY format
e) Occupation	Indicate Occupation of Patient	Please specify the Occupation
f) Telephone Number	Enter the Phone Number of Policyholder	Include STD code with telephone number
g) Mobile No	Enter the Mobile Number of Policyholder	Please enter a 10 digit number
h) E-mail Address	Enter E-mail Address of Policyholder	Complete E-mail Address
<b>Section B - Details of the Insured in respect of whom claim is made</b>		
a) Name of Insured Person	Enter the Full Name of the Insured	First Name, Middle Name, Surname
b) Address	Enter the Full Postal Address	Include Street, City, State and Pin Code
c) Date of Birth	Enter Date of Birth of Insured	Use DD/MM/YYYY format
d) Occupation	Indicate Occupation of Insured	Please specify the Occupation.
e) Telephone Number	Enter the Phone Number of Insured	Include STD code with telephone number
f) Mobile No	Enter the Mobile Number of Insured	Please enter a 10 digit number
g) E-mail	Enter E-mail Address of Insured	Complete E-mail Address
h) Relationship with Policy Holder	Indicate Relationship of Insured with Policyholder	Please specify the relationship
i) Date (DD/MM/YYYY) and Time of Injury/ Death	Enter the Date of Injury/ Death	Use DD/MM/YYYY format
j) Place of Accident/ Injury/ Death	Enter the Place where the Accident/ Injury or Death Occurred	Enter Locality, City, State
k) Details and Nature of Accident	Enter details of reason and nature of Accidental Injuries	Describe the nature of Injuries and reason for Accident
l) Did the Accident happen when you were working	Indicate whether the Accident happen when you were working	Tick Yes or No
m) If Yes, Name and Address of Employer	Indicate the Full Postal Address	Include Street, City, State and Pin Code
n) Whether reported to Police	Indicate Whether you have informed and reported to Police	Tick Yes or No
o) If Yes, Name and Address of Police Station	Indicate the Full Postal Address	Include Street, City, State and Pin Code
p) If No, Give reasons	Indicate the reason for Not informing the Police	Indicate the reason for Not informing the Police
q) First Information Report (FIR) Number	Indicate the FIR number	Please give complete FIR number and Date
r) Contact Details of Police Station	Indicate the Telephone number and address of Police station	Include STD code with telephone number/ Address - Include Street, City, State and Pin Code
<b>Section C - Details of Hospitalization immediately after the accident</b>		
a) Name of the Hospital	Indicate the Full Name	Indicate the Full Name
b) Address of the Hospital	Indicate the Full Postal Address	Include Street, City, State and Pin Code
c) Date of Admission	Enter Date of Admission	Use DD/MM/YYYY format
d) Date of Discharge	Enter Date of Discharge	Use DD/MM/YYYY format
<b>Section D - Details of Witnesses</b>		
a) Was there any witness to the event	Indicate if there any witness to the event	Tick Yes or No
b) Name	Enter the Full Name of the Witness	First Name, Middle Name, Surname
c) Address	Enter the Full Postal Address	Include Street, City, State and Pin Code
d) Phone Number (Home)	Enter the Phone Number of Patient	Include STD code with telephone number
e) Phone Number (Mobile)	Enter the Mobile Number of Patient	Please enter a 10 digit number
f) Phone Number (Work)	Enter the Phone Number of Patient	Include STD code with telephone number
<b>Section E - Details of any other personal accident policy</b>		
a) Name of the Insurer	Indicate Full Name	Name - Enter Full Name
b) Address of Issuing office	Indicate Address of Insurer's Issuing office	Include Street, City, State and Pin Code
c) Policy Number	Enter the Policy Number	As allotted by the Insurance Company
d) Policy Period	Enter the Policy Commencement and End Date	DD/MM/YYYY to DD/MM/YYYY
e) Sum Insured	Enter the Total Sum Insured as per the Policy	In Rupees
<b>Section F - Details of Benefits Claimed</b>		
Please Indicate and Tick the Benefits claimed		
<b>Section G - Check List of Enclosures for Submission of Claim</b>		
Indicate which bills are enclosed with the Amounts in Rupees		
<b>Section H - Details of Policyholders Bank Account</b>		
a) Bank Name	Enter the Bank Name	Name of the Bank in full
b) Bank Branch	Enter Name of the Branch	Name of the Branch
c) Bank Account Number	Enter the Bank Account Number	As allotted by the Bank
d) IFSC Code	Enter the IFSC Code of the Bank Branch	IFSC Code of the Bank Branch in full
e) MICR Code	Enter the MICR Code	MICR Code of the Bank Branch in full
<b>Section I - Declaration by the Insured</b>		
Read Declaration carefully and mention date (in DD/MM/YYYY 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.

## ID proof (Any one of below mentioned documents required)

- Passport\*
- PAN Card
- Voter's Identity card
- Driving license
- Letter issued by Unique Identification Authority of India containing details of name, address and Aadhar number
- Job card issued by NREGA duly signed by an officer of the State Government
- Color passport size photograph not older than 6 months



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

- Electricity bill / Ration card\*
- Letter from any recognized 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

Request you to provide declaration for crediting claim amount in your (proposer) account provided during policy issuance. YES  NO

We shall use below mentioned information from the policy for payment of your claim:

- Account Number
- Bank Name
- Payee Name
- IFSC code
- Branch Name