CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED

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

MAGMA HDI
General Insurance Company Ltd.

Toll Free No. 1800 266 3202

SECTION A - DETAILS OF PRIMARY INSURED: (To be filled in block letters)

a) Policy No: b) SI. No/ Certificate No:

c) Company/ TPA ID No:

d) Name:

e) Address:

City: State:

Pin Code: Landline (With STD Code):

Mobile No:

[PLEASE PROVIDE ACTIVE EMAIL ID ONLY AS CLAIMS CORRESPONDENCE WILL BE SENT TO THIS EMAIL ID.]

Email ID:

Alternate Email ID:

SECTION B - DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: ☐ Yes ☐ No b) If yes, Policy Type: ☐ Individual ☐ Group

Company Name: Policy No.:

c) Date of commencement of first Insurance without break: d) Sum Insured (Rs.):

Have you been hospitalised in the last four years since inception of the contract? ☐ Yes ☐ No

Diagnosis:

f) Previously covered by any other Mediclaim / Health Insurance: ☐ Yes ☐ No

g) If yes, Company Name:

SECTION C - DETAILS OF INSURED PERSON HOSPITALISED:

a) Name:

b) Gender: ☐ Male ☐ Female c) Age: Years (Y Y) Months (M M) d) Date of Birth: (D D M M Y Y Y Y)

e) Relationship to Primary Insured: ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please Specify)

f) Address (if different from above):

City: State:

Pin Code: Phone No:

Email ID:

g) Occupation: ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please specify)

h) Name of Employer/ Firm's Name:

i) Address of the Employer/Firm:

SECTION D - DETAILS OF HOSPITALISATION:

a) Name & Address of Hospital where Admitted:

City: State:

Pin Code: Landmark:

b) Room Category occupied: ☐ Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room

☐ Other (Please specify)

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

d) Date of Injury / Date Disease first detected / Date of Delivery: (D D M M Y Y Y Y)

e) Date of Admission: (D D M M Y Y) f) Time: (H H : M M) g) Date of Discharge: (D D M M Y Y) h) Time: (H H : M M)

i) In case of maternity, I) Date of Delivery: (D D M M Y Y) II) Gravida Status:

j) If injury give cause: ☐ Self-inflicted ☐ Road Traffic Accident ☐ Substance Abuse / Alcohol Consumption

I) If Medico Legal: ☐ Yes ☐ No II) Reported to police: ☐ Yes ☐ No

III) MLC Report & Police FIR attached: ☐ Yes ☐ No

k) System of Medicine:

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SECTION E - DETAILS OF CLAIM:

a) Details of the other treatment expenses claimed

S.N.	Cover Name	Amount (in Rs)	S.N.	Cover Name	Amount (in Rs)
	Pre Hospitalization Expenses			Green channel benefit claim against Health wearable device	
	Post Hospitalization Expenses			Compassionate Visit in case of CI	
	Ambulance Cover			Vaccination for new born	
	Organ Donor Expenses			Out-patient Cover	
	Green channel benefit claim against Non payable expenses			Air Ambulance	
	Worldwide emergency optional cover			Maternity benefit optional cover	

• For new born baby cover, separate claim form to be filled & submitted. • For Fitness Reward points, please fill separate form "Fitness reward earning claim form" available on our website. • Benefits under Cumulative Bonus, Early joining Benefit, Restoration of Sum Insured will be provided automatically. You need not file a claim separately for these.

b) Details of Lump sum / cash benefit claimed

S.N.	Cover Name	Claimed	S.N.	Cover Name	Claimed
	Hospital Cash	☐ Yes ☐ No		Companion Benefit	☐ Yes ☐ No
	Loss of income benefit	☐ Yes ☐ No		Convalescence Benefit	☐ Yes ☐ No
	Enhanced Daily cash benefit	☐ Yes ☐ No		Benefit under Critical Illness optional Cover, if opted	☐ Yes ☐ No
	Home treatment additional daily Cash benefit	☐ Yes ☐ No		Benefit under Personal Accident optional Cover, if opted	☐ Yes ☐ No
	Hospital cash optional cover	☐ Yes ☐ No			

Amount as per above covers, if claimed by you, will be paid as per the terms and conditions of the Policy plan.

Check List of Claim Documents to be submitted (In original)* - Please (✓) tick relevant box

(For Hospital Cash benefit, photocopies of claim documents are acceptable)

☐ Claim Form duly filled and signed	☐ Copy of the Claim Intimation, if any	☐ Hospital Bill Payment receipt
☐ Hospital Main Bill	☐ Hospital Break-up Bill	☐ Doctor's request for investigation
☐ Hospital Discharge Summary	☐ Pharmacy Bill	☐ Operation Theatre Notes
☐ Investigation Reports (Including CT / MRI / USG / HPE / ECG)		☐ Test report and prescription relating to first consultation for the Illness
☐ Doctor's prescription for medicines purchased outside the hospital and investigation done outside hospital		☐ FIR / MLC in case of accident injury and English translation of the same if it is in any other language
☐ KYC document (Address proof, ID proof only for claims exceeding ₹1 Lakh)		☐ Original Death Summary (Wherever applicable)
☐ Cancelled cheque leaf of the bank account held in the name of the primary insured (Mandatory)		☐ Any Other

*Please retain copy of complete set of claim documents for your records

SECTION F - DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1.				Hospital Main Bill	
2.				Pre-hospitalisation Bills: Nos	
3.				Post-hospitalisation Bills: Nos	
4.				Pharmacy Bills	
5.					
6.					
7.					
8.					
9.					
10.					

Note: If there are more bills, please attach additional sheets with this claim form giving the bill details in same format as below.

Hospital Main Bill Payment Receipts only

Receipt No.	Date	Amount (Rs)	Please (✓) Tick Relevant Box	
			☐ Advance Receipt	☐ Final Receipt
			☐ Advance Receipt	☐ Final Receipt
			☐ Advance Receipt	☐ Final Receipt
			☐ Advance Receipt	☐ Final Receipt

Note: Please attach separate sheet if necessary

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IF THE CLAIM IS FOR ACCIDENTAL INJURIES, PLEASE PROVIDE DETAILS OF DATE, TIME AND CIRCUMSTANCES OF ACCIDENT EVENT AND OTHER DETAILS AS RELEVANT:

Date: D D M M Y Y Y Y Time: H H : M M

Circumstances of Accident event and other details: _____

SECTION G - DETAILS OF PRIMARY INSURED's BANK ACCOUNT:

PLEASE PROVIDE YOUR BANK DETAILS: (PLEASE ATTACH CANCELLED CHEQUE LEAF OF BANK ACCOUNT IN THE NAME OF PRIMARY INSURED WITHOUT FAIL)

a) PAN: b) Account Number:

c) Bank Name and Branch:

d) IFSC Code:

e) Cheque/ DD Payable Details:

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, suppressed or concealed 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 the person for 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 pre/post hospitalization claim and for additional covers, if any.

Date: D D M M Y Y Y Y

Place:

Signature of the Insured:

Please send this duly filled and signed claim form to our TPA at below address:

Family Health Plan Insurance TPA Limited

Srinilaya - cyber spazio suite, 101,102,Ground Floor, Road No. 2, Banjara Hills, Hyderabad, Telangana 500034

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) i. Company Name	Enter the full name of the insurance company	Name of the organisation in full
b) ii. Policy No.	Enter the policy number	As allotted by the insurance company
c) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
d) Sum Insured	Enter the total sum insured as per the policy	In rupees
Have you been Hospitalised in the last four years since inception of the contract?	Indicate whether hospitalised in the last four years	Tick Yes or No
f) Date	Enter the date of hospitalisation	Use mm-yy format
g) Diagnosis	Enter the diagnosis details	Open Text
h) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
i) Company Name	Enter the full name of the insurance company	Name of the organisation in full

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

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate gender of the patient	Tick Male or Female
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) Address	Enter the full postal address	Include Street, City and Pin Code
Phone No.	Enter the phone number of patient	Include STD code with telephone number
E-mail ID	Enter e-mail address of patient	Complete e-mail address
g) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify
i) Address of the Employer	Complete address of the employer of the Insured	Include Street, City and Pin Code
SECTION D - DETAILS OF HOSPITALISATION FOR CLAIM BEING FILED		
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) In case of maternity		
I. Date of delivery	Enter date of delivery	Use dd-mm-yy format
ii. Gravida Status	Enter Gravida Status	Use standard format
j) If Injury give cause	Indicate cause of injury	Tick the right option
i. If Medico Legal	Indicate whether injury is Medico Legal	Tick Yes or No
ii. Reported to Police	Indicate whether police report was filed	Tick Yes or No
iii. MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
k) 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 hospitalization	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) 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.		