

**SHRI ALL BENEFIT HEALTH INSURANCE (ABHI) GROUP HEALTH BENEFIT POLICY  
CLAIM FORM - PART A**

Issuance of this form does not amount to admission of any liability or a waiver of any of the terms and conditions of the insurance contract. If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or any Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy shall be void and all benefits paid under it shall be forfeited.

|                     |                                                                                                                                                                                                                                                                                                                                                            |                                  |                                                                                                                                                                         |
|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| POLICY NUMBER       | <input type="text"/>                                                                                                                                                                                                                                                                                                                                       | CLAIM NUMBER                     | <input type="text"/>                                                                                                                                                    |
| Period of Insurance | From <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/><br>To <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Date of First Joining the Policy | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |

**SECTION A. DETAILS OF THE INSURANCE/CLAIMANT**

|                                  |                                                                                                                                                                         |                                 |                                                                                               |
|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-----------------------------------------------------------------------------------------------|
| 1. Name of the Insured Patient   | <input type="text"/>                                                                                                                                                    |                                 |                                                                                               |
| 2. Name of the Claimant          | <input type="text"/>                                                                                                                                                    |                                 |                                                                                               |
| 3. Relationship with the Insured | <input type="text"/>                                                                                                                                                    |                                 |                                                                                               |
| 4. Date of Birth                 | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | 5. Gender                       | Male <input type="checkbox"/> Female <input type="checkbox"/> Others <input type="checkbox"/> |
| 6. Address                       | <input type="text"/>                                                                                                                                                    |                                 |                                                                                               |
|                                  | City <input type="text"/>                                                                                                                                               | State <input type="text"/>      | Pin code <input type="text"/>                                                                 |
| 7. Contact Details               | Phone No. <input type="text"/>                                                                                                                                          | Mobile No. <input type="text"/> |                                                                                               |
|                                  | Email Id <input type="text"/>                                                                                                                                           |                                 |                                                                                               |

**SECTION B. SECTIONS UNDER WHICH CLAIMING THE BENEFIT**

|                                                      |                                                     |
|------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Hospital Daily Cash Benefit | <input type="checkbox"/> Cancer Care                |
| <input type="checkbox"/> Personal Accident Benefits  | <input type="checkbox"/> Heart Care                 |
| <input type="checkbox"/> Criticare Lumpsum Benefit   | <input type="checkbox"/> Broken Bones               |
| <input type="checkbox"/> EMI Protection              | <input type="checkbox"/> Accidental Burn Cover      |
| <input type="checkbox"/> Out Patient Treatment       | <input type="checkbox"/> Accidental Hospitalization |

**SECTION C. DETAILS OF INSURANCE HISTORY**

|                                                                                   |                                                          |                                                               |                                                                                                                                                                         |
|-----------------------------------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| a) Currently covered by any other mediclaim health insurance:                     | Yes <input type="checkbox"/> No <input type="checkbox"/> | b) Date of commencement of first insurance without break      | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <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 hospitalized in the last 4 years since inception of the contract | Yes <input type="checkbox"/> No <input type="checkbox"/> | d (i). If YES (specify Date & duration)                       | <input type="text"/>                                                                                                                                                    |
| d(ii) If YES (specify the Diagnosis)                                              | <input type="text"/>                                     | e) Previously covered by any other Mediclaim/Health insurance | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                |
| e(i) If Yes, Company Name:                                                        | <input type="text"/>                                     |                                                               |                                                                                                                                                                         |

**SECTION D. DETAILS OF ILLNESS /ACCIDENT / EVENT DURING HOSPITALIZATION**

|                                                         |                                                                                                  |  |  |  |  |  |  |  |  |                                  |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|---------------------------------------------------------|--------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|----------------------------------|--------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|----------|--------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|
| 1. Diagnosed Illness                                    |                                                                                                  |  |  |  |  |  |  |  |  |                                  |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| 2. Signs & symptoms of Illness                          |                                                                                                  |  |  |  |  |  |  |  |  |                                  |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| 3. (i) When was the illness first Diagnosed / detected? | <table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |  |  |  |  |  |  |  |  | 3. (ii) Date & Time of Admission | <table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|                                                         |                                                                                                  |  |  |  |  |  |  |  |  |                                  |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|                                                         |                                                                                                  |  |  |  |  |  |  |  |  |                                  |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|                                                         |                                                                                                  |  |  |  |  |  |  |  |  |                                  |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|                                                         |                                                                                                  |  |  |  |  |  |  |  |  |                                  |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| 3. (iii) Date & Time of Discharge                       | <table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |  |  |  |  |  |  |  |  |                                  |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|                                                         |                                                                                                  |  |  |  |  |  |  |  |  |                                  |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| 4. Name of Treating Doctor                              |                                                                                                  |  |  |  |  |  |  |  |  |                                  |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| 5. Name of Hospital                                     |                                                                                                  |  |  |  |  |  |  |  |  |                                  |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| 6. Address of Hospital                                  |                                                                                                  |  |  |  |  |  |  |  |  |                                  |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| City                                                    | <table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |  |  |  |  |  |  |  |  | State                            | <table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |  |  |  |  |  |  |  |  | Pin code | <table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |  |  |  |  |  |  |  |  |
|                                                         |                                                                                                  |  |  |  |  |  |  |  |  |                                  |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|                                                         |                                                                                                  |  |  |  |  |  |  |  |  |                                  |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|                                                         |                                                                                                  |  |  |  |  |  |  |  |  |                                  |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |

**SECTION E. DETAILS OF ACCIDENTAL INJURY LEADING TO DISABILITY OR DEATH**

|                                                                                         |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------|--|--|--|--|--|--|-----------------------------|--------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|----------|--------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|
| 1. Name of the Insured Person dead/injured in the accident                              |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| 2. Date of Accident                                                                     | <table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>             |                               |                                                          |  |  |  |  |  |  | Time of Accident            | AM <input type="checkbox"/> PM <input type="checkbox"/> .....                                    |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|                                                                                         |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| 3. Place of Accident occurred:                                                          |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| 4. Exact circumstances of accident (attach separate sheet If needed)                    |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| 5. Permanent Disablement?                                                               | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                     | 6. Temporary Disablement?     | Yes <input type="checkbox"/> No <input type="checkbox"/> |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| 7. Period of Temporary Total Disablement:                                               | From <table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>        |                               |                                                          |  |  |  |  |  |  | To                          | <table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|                                                                                         |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|                                                                                         |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| 8. Any Modification of Residential Accommodation or Vehicle done?                       | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                     |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| 9. Expenditure towards Hospitalization for the injury or disability management (in Rs.) |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| 10. Expenditure towards transportation on of mortal remains (in Rs.)                    |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| 11. Details of the Hospital, where the above Treatment / Management is done;            |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| Name of Treating Doctor                                                                 |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| Name of Hospital                                                                        |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| Address of Hospital                                                                     |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| City                                                                                    | <table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>             |                               |                                                          |  |  |  |  |  |  | State                       | <table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |  |  |  |  |  |  |  |  | Pin code | <table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |  |  |  |  |  |  |  |  |
|                                                                                         |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|                                                                                         |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|                                                                                         |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| 12. Cause of the Insured's Death (in case of Accidental Death)                          |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| 13. Was an autopsy (Post Mortem) performed?                                             | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                     |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| If yes, provide name, address and contact number of the medical examiner                |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| 14. Police Report Details                                                               |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| Informed to Police ?                                                                    | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                     | If No (please provide reason) |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
| If Yes (provide details)                                                                | FIR No. <table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>     |                               |                                                          |  |  |  |  |  |  | Medico Legal Case (MLC) No. | <table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|                                                                                         |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|                                                                                         |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|                                                                                         | Report Date <table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |                               |                                                          |  |  |  |  |  |  | Police Station Name         | <table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|                                                                                         |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |
|                                                                                         |                                                                                                              |                               |                                                          |  |  |  |  |  |  |                             |                                                                                                  |  |  |  |  |  |  |  |  |          |                                                                                                  |  |  |  |  |  |  |  |  |

**SECTION F. DETAILS OF ANY OTHER BENEFIT INSURANCE FOR ANY ILLNESS / EVENT CLAIMED**

|                                                                                         |                                                          |
|-----------------------------------------------------------------------------------------|----------------------------------------------------------|
| 1. Have you incurred any claim under similar Fixed Benefit Plans or any other insurance | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If Yes, please provide details                                                          |                                                          |

**SECTION G. PAYEE DETAILS OF PRIMARY INSURED'S BANK ACCOUNT**

|                          |                      |             |                      |
|--------------------------|----------------------|-------------|----------------------|
| Bank Account Holder Name | <input type="text"/> |             |                      |
| Bank Name                | <input type="text"/> | Bank Branch | <input type="text"/> |
| Bank Account No.         | <input type="text"/> | IFSC Code   | <input type="text"/> |
| MICR No.                 | <input type="text"/> | PAN No.     | <input type="text"/> |

Note: It is agreed that the Policyholder/Claimant will intimate in writing to SGI, about any change in bank account details. Please attach a cancelled cheque pertaining to the same account

**SECTION H. TO BE FILLED BY NOMINEE (IN THE EVENT OF POLICY HOLDER'S DEATH)**

|                  |                                                                                                                                                                         |                                |                      |
|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------|
| Name of Nominee  | <input type="text"/>                                                                                                                                                    |                                |                      |
| Address          | <input type="text"/>                                                                                                                                                    |                                |                      |
| Date of Birth    | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Relationship with the Deceased | <input type="text"/> |
| Telephone Number | <input type="text"/>                                                                                                                                                    | Mobile Number                  | <input type="text"/> |
| Email ID:        | <input type="text"/>                                                                                                                                                    |                                |                      |

DECLARATION BY NOMINEE (IN THE EVENT OF POLICY HOLDER'S DEATH):

I/We hereby declare that the foregoing particulars are true & correct to the best of my knowledge and belief. I also authorize Insurance Company to make payment of the claim admissible as per terms, conditions and limitations to the Insured person or his legal heir as full and final settlement. I/We will keep indemnified and hold SGI Health Insurance Co. harmless from any claim under this policy by any third party.

|               |                                                                                                                                                                         |       |                      |           |                      |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|----------------------|-----------|----------------------|
| Date of Birth | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Place | <input type="text"/> | Signature | <input type="text"/> |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|----------------------|-----------|----------------------|

**SECTION I. TO BE FILLED BY EMPLOYER / GROUP POLICY HOLDER (ONLY FOR GROUP POLICY)**

|                                          |                      |                            |                      |
|------------------------------------------|----------------------|----------------------------|----------------------|
| Name of Company / Group policy holder    | <input type="text"/> |                            |                      |
| Address & contact details of the company | <input type="text"/> |                            |                      |
| Name of The Employee                     | <input type="text"/> |                            |                      |
| Date of joining service                  | <input type="text"/> | 5. Designation of Employee | <input type="text"/> |

Please provide the details of leave availed by your employee;

| S.NO | Date from which leave is taken | Date when resumed duties | No.of days leave applied | Type of leave | In case of sick leave, Medical Certificate Submitted (YES/ NO) | Reason for Leave |
|------|--------------------------------|--------------------------|--------------------------|---------------|----------------------------------------------------------------|------------------|
|      |                                |                          |                          |               |                                                                |                  |

|                              |                      |                                                  |                      |
|------------------------------|----------------------|--------------------------------------------------|----------------------|
| Name of Authorised Signatory | <input type="text"/> | Seal & Signature of the Signatory of the Company | <input type="text"/> |
| Designation of Signatory     | <input type="text"/> |                                                  |                      |

**SECTION J. ENCLOSURE CHECKLIST – HOSPITALISATION CLAIM**

|                                                                                          |                                                                        |
|------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Claim Form Duly Filled & Signed                                 | <input type="checkbox"/> Out Patient and/or Hospital Discharge Summary |
| <input type="checkbox"/> Treating Doctor's Certificate for Diagnosis of critical illness | <input type="checkbox"/> All Investigation Reports                     |
| <input type="checkbox"/> Hospital Main Final Bill                                        | <input type="checkbox"/> OT Notes (in surgery case)                    |
| <input type="checkbox"/> CKYC Application Form (if claimed amount is more than Rs.1 Lac) | <input type="checkbox"/> Photo Identity Proof                          |
| <input type="checkbox"/> Policy & Endorsement Copy                                       | <input type="checkbox"/> Death Certificate (In Death Claims)           |
| <input type="checkbox"/> Doctor's Prescription for Investigation (CT, HR, VSG, HPE)      | <input type="checkbox"/> PMR Certificate (in Death Claims)             |
| <input type="checkbox"/> FIR/MLC Copy (where applicable)                                 | <input type="checkbox"/> Indoor Case papers. If applicable             |

**SECTION K. 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 & authorize 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-hospitalization claim, if any.

|               |                                                                                                                                                                         |       |                      |           |                      |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|----------------------|-----------|----------------------|
| Date of Birth | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Place | <input type="text"/> | Signature | <input type="text"/> |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|----------------------|-----------|----------------------|

CIN No. U66010RJ2006PLC029979

IRDA Registration Number: 137



Shriram General Insurance Co. Ltd.

IN PARTNERSHIP WITH THE Sanlam GROUP

Regd. &amp; Corp. Office: E-8, EPIP, RIICO Industrial Area, Sitapura, Jaipur (Rajasthan) – 302022

Phone: +91-141-392 8400, 395 1111, Fax: +91-141-277 0692, 277 0693

Website: [www.shriramgi.com](http://www.shriramgi.com), E-mail: [customer.feedback@shriramgi.in](mailto:customer.feedback@shriramgi.in)

Toll Free: 1800-103-3009, 1800-300-30000

ISO/IEC 27001:2013 certified

## SHRI ALL BENEFIT HEALTH INSURANCE (ABHI) GROUP HEALTH BENEFIT POLICY CLAIM FORM - PART B - (TO BE COMPLETELY FILLED BY THE HOSPITAL)

### SECTION A. DETAILS OF TREATING DOCTOR & HOSPITAL

|                                     |                                                                                                                                     |                                     |                      |
|-------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------|
| a) Name of the hospital             | <input type="text"/>                                                                                                                |                                     |                      |
| b) Name of the training doctor      | <input type="text"/>                                                                                                                |                                     |                      |
| c) Rohini ID/Hospital ID            | <input type="text"/>                                                                                                                | d) Registration No. with State Code | <input type="text"/> |
| e) Phone Number                     | <input type="text"/>                                                                                                                | f) City                             | <input type="text"/> |
| g) Pin Code                         | <input type="text"/>                                                                                                                | h) State                            | <input type="text"/> |
| i) Hospital PAN                     | <input type="text"/>                                                                                                                | j) No. of inpatients beds           | <input type="text"/> |
| k) Facilities available in hospital | (i) OT: Yes <input type="checkbox"/> No <input type="checkbox"/> (ii) ICU: Yes <input type="checkbox"/> No <input type="checkbox"/> |                                     |                      |

### SECTION B. DETAILS OF THE PATIENT ADMITTED

|                                          |                                                                                                                                                                                                 |                      |                                                                                              |
|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------------------------------------------------------------------------|
| a) Name of the Patient                   | <input type="text"/>                                                                                                                                                                            |                      |                                                                                              |
| b) IP Registration No.                   | <input type="text"/>                                                                                                                                                                            | c) Gender            | Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> |
| d) Date of Birth                         | <input type="text"/>                                                                                                                                                                            | e) Age of patient    | <input type="text"/>                                                                         |
| f) Date of Admission                     | <input type="text"/>                                                                                                                                                                            | Time of Admission    | <input type="text"/>                                                                         |
| g) Date of Discharge                     | <input type="text"/>                                                                                                                                                                            | Time of Discharge    | <input type="text"/>                                                                         |
| h) Type of Admission                     | Emergency <input type="checkbox"/> Planned <input type="checkbox"/> Day Care <input type="checkbox"/>                                                                                           |                      |                                                                                              |
| i) Status at the time of Discharge       | Discharge to home <input type="checkbox"/> Discharge to another hospital <input type="checkbox"/> Deceased <input type="checkbox"/>                                                             |                      |                                                                                              |
| j) Total Hospitalisation Expenses (in ₹) | <input type="text"/>                                                                                                                                                                            |                      |                                                                                              |
| k) Room Category Occupied                | Deluxe <input type="checkbox"/> Suite <input type="checkbox"/> Single Standard <input type="checkbox"/> Double Sharing Room <input type="checkbox"/> Multi Bedded Room <input type="checkbox"/> |                      |                                                                                              |
| m) Any stay in ICU?                      | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                        |                      |                                                                                              |
| If ICU Stay (Period of ICU)              | From                                                                                                                                                                                            | <input type="text"/> | To <input type="text"/>                                                                      |

### SECTION C. DETAILS OF AILMENT DIAGNOSED (PRIMARY)

|                                                               |                                                          |                            |                                                                                                                            |
|---------------------------------------------------------------|----------------------------------------------------------|----------------------------|----------------------------------------------------------------------------------------------------------------------------|
| a) Diagnosis                                                  | b) If any, procedure done                                |                            |                                                                                                                            |
| i) Primary Diagnosis:                                         | <input type="text"/>                                     | i) Procedure 1:            | <input type="text"/>                                                                                                       |
| ii) Additional Diagnosis:                                     | <input type="text"/>                                     | ii) Procedure 2:           | <input type="text"/>                                                                                                       |
| iii) Co-morbidities:                                          | <input type="text"/>                                     | iii) Procedure 3:          | <input type="text"/>                                                                                                       |
| iv) Co-morbidities:                                           | <input type="text"/>                                     | iv) Details of Procedure 1 | <input type="text"/>                                                                                                       |
| c) Present ailment is a complication of Pre-existing disease: | Yes <input type="checkbox"/> No <input type="checkbox"/> |                            |                                                                                                                            |
| (If Yes, specify disease, Its duration and other details)     | <input type="text"/>                                     |                            |                                                                                                                            |
| d) Hospitalization due to Injury                              | Yes <input type="checkbox"/> No <input type="checkbox"/> | If yes, give cause:        | Self-Inflicted <input type="checkbox"/> Road Accident <input type="checkbox"/> Any other Accident <input type="checkbox"/> |
| e) Is it Medico Legal Case?                                   | Yes <input type="checkbox"/> No <input type="checkbox"/> | f) Reported to Police      | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                   |
| g) MLC Report & Police FIR attached with claim documents      | Yes <input type="checkbox"/> No <input type="checkbox"/> |                            |                                                                                                                            |

UIN NO. SGLHLP24105V012324

**SECTION D. TO BE FILLED BY TREATING DOCTOR****1. Details of the consultation by the Patient for present illness/ injury.**

- a) Date of first consultation
- b) Presenting Complaints
- c) Nature of illness/injury
- d) History reported
- e) Extent of Illness/injury
- f) Diagnosis
- g) Treatment given
- h) If hospitalized
- Date of Admission  Time of Admission
- Date of Discharge  Time of Discharge

2. Has the patient sustained a similar Illness/ injury previously or aggravated a pre-existing condition? Yes ☐ No ☐

If Yes, please give details:

**3. For Personal Accident Cover opted Cover (in case of PA)**

- a) Are Injuries sustained in this accident the sole cause of disablement: Yes ☐ No ☐
- b) If injury, please specify the number of days when the injured person is advised rest/unfit and should be confined to bed/house as the direct and sole consequence of the injury sustained
- From:  To:
- c) Will the Injured person be able to attend to his/her normal duties? Yes ☐ No ☐
- d) If Yes, from which date:
4. If injury, was he/she under the influence of alcohol/intoxicants or drugs at the time of accident? Yes ☐ No ☐
5. Nature of Disablement:
- a) Permanent Total Disablement: Yes ☐ No ☐ b) Permanent Partial Disablement: Yes ☐ No ☐
- c) Please specify percentage: \_\_\_\_\_ %
6. In case of injury due to major burns:
- a) Nature and Extent of Burns Injury:
- b) Percentage of surface area of Burns: \_\_\_\_\_ %

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

Qualification

Contact Number

Registration No

Address

Signature

**SECTION E. DECLARATION BY THE HOSPITAL (PLEASE READ CAREFULLY)**

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date

Place

Signature of  
Hospital