SBI General Insurance Company Limited
IRDA Reg. No. 144 dated 15/12/2009 | CIN: U66000MH2009PLC190546

Call (Toll Free)
1800 22 1111 | 1800 102 1111
www.sbigeneral.in

HOSPITAL DAILY CASH POLICY

Claim Form

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 No. Claim No.

Period of Insurance From D D M M Y Y Y Y To D D M M Y Y Y Y

A. DETAILS OF INSURED/CLAIMANT

1. Name of the Claimant SURNAME MIDDLENAME FIRSTNAME
2. Name of the Insured SURNAME MIDDLENAME FIRSTNAME
3. Name of hospitalized person SURNAME MIDDLENAME FIRSTNAME
4. Relationship with Insured Date of Birth D D M M Y Y Y Y Gender ☐ Male ☐ Female
5. Address
   Plot No/Door No. Building Name
   Road Area
   City Pincode
   State
6. Contact Details
   Phone No. Mobile
   E-mail Id

B. DETAILS OF ILLNESS/ACCIDENT

1. Diagnosis of illness
2. Signs and symptoms of illness
3. When did you first notice signs and Symptoms of the illness? D D M M Y Y Y Y
   When did you first consult your doctor for the illness? D D M M Y Y Y Y
4. When was the illness first diagnosed/detected? D D M M Y Y Y Y
5. Have you ever had the similar illness in past? ☐ Yes ☐ No
   If 'Yes', provide details,
6. Any other past history
7. Name of the Doctor consulted first
8. Contact Details
   Phone No. Mobile
   E-mail Id
9. Date & Time of Admission D D M M Y Y Y Y : A.M. / P.M.
10. Type of Room on the day of admission ☐ ICU ☐ Non-ICU
11. Date & Time of Discharge D D M M Y Y Y Y : A.M. / P.M.
12. No of Days in ICU No of Days in Non-ICU/Room/Ward

Version 1.0, Nov 2014

13. Type of Claim ☐ Accidental Hospitalization ☐ Illness Hospitalization ☐ Convalescence Benefit

14. Name of the first Consulted Doctor

15. Name of the Hospital

16. Phone No. Email ID

17. OP No./Hospital No./Indoor Patient No. Date of first visit to Hospital in this regard D D M M Y Y Y Y

18. Name of treating Doctor

19. Qualification of treating Doctor Treating Doctors Registration No.

20. Address of the Hospital Plot No/Door No. Building Name

Road Area

City Pincode

State

21. Contact Details Phone No. Mobile

E-mail Id

C. DETAILS OF PREVIOUS HEALTH CLAIM

1. Have you incurred any claim before? ☐ Yes ☐ No

If 'Yes', please provide details

D. DETAILS OF OTHER INSURANCE

1. Is the Accident/Incidence covered under any other Insurance? ☐ Yes ☐ No

If 'Yes', specify details and attach a copy of the policy

Name of Insurer Policy No.

Policy Issuance Office Location Sum Insured (Rs.)

Period of insurance From D D M M Y Y Y Y To D D M M Y Y Y Y

E. FOR WHICH BENEFIT DO YOU CLAIM? [PLEASE TICK (✓) THE APPROPRIATE BOX]

Benefit	Amount claimed	Benefit	Amount claimed
☐ Hospital Daily Cash ☐☐ No. of days		☐ Convalescence Benefits	

F. ENCLOSURE CHECKLIST

☐ Claim Form duly filled & signed ☐ Hospital / Discharge Summary ☐ Final Hospital Bill-paid ☐ Investigation Reports

☐ Doctor's Certificate ☐ Any other documents, please specify

G. PAYEE DETAILS (*All fields are mandatory)

Bank Name Bank Branch

Bank Account No. IFSC Code

MICR No. PAN No.

Note: It is agreed that the Policyholder/Claimant will intimate in writing to SBI General about any change in bank account details. Please attach a cancelled cheque pertaining to the same account. In case premium is issued from the same bank account through cheque, the cancelled cheque is not required.

H. ANY OTHER INFORMATION YOU MAY WISH TO PROVIDE

I. 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, 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. 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 expect the pre/post hospitalization claim, if any.

I/We hereby extend my/our consent to the Company for sharing my/our personal data with State Bank Group entities for specific purpose of availing services offered by State Bank Group(please strike this clause in case you do not wish to disclose the personal data).

Place Signature of Insured/Claimant

Date D D M M Y Y Y Y Name of Insured/Claimant

MEDICAL CERTIFICATE : To be filed by treating doctor

A. DETAILS OF HOSPITAL

a) Name of the hospital:

b) Name of the treating doctor: SURNAME MIDDLENAME FIRSTNAME

c) Qualification:

d) Registration no with State Code:

f) Phone No:

B. DETAILS OF THE PATIENT ADMITTED

a) Name of the patient: SURNAME MIDDLENAME FIRSTNAME

b) IP Registration No:

c) Gender: Male ☐ Female ☐

d) Age: Years Months

e) Date of birth: DD MM YYYY

f) Date of Admission: DD MM YYYY

g) Time: HH : MM

h) Date of discharge: DD MM YYYY

i) Time: HH : MM

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐

k) Status at the time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐

C. DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a) Diagnosis

i Primary Diagnosis:

ii Additional Diagnosis:

iii Co-morbidities:

iv Co-morbidities:

b) If any, Procedure done detail — Description

I Procedure 1:

ii Procedure 2:

iii Procedure 3:

iv Details of Procedure1

c) Present ailment is a complication of Pre-existing disease ☐ Yes ☐ No (If Yes, specify details)

d) Hospitalization due to Injury: ☐ Yes ☐ No i) If Yes, give cause Self-Inflicted ☐ Road Accident ☐ Any other Accident ☐

ii) If Injury due Substance abuse/ alcohol consumption, Test Conducted to establish this: ☐ Yes ☐ No (If Yes, attach report) iii) If Medico legal: ☐ Yes ☐ No

iv) Reported to Police: ☐ Yes ☐ No v) If not reported to police give reason:

I certify that I have examined the above named Insured, the above statements are correct

Name of treating Doctor

Qualifications Registration No.

Address

Contact Details Phone No.

E-mail Id

Signature of the Doctor _____ Date DD MM YYYY

Stamp of the Doctor _____ Stamp of the Hospital _____

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, 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. 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 expect the pre/post hospitalization claim, if any.

I/We hereby extend my/our consent to the Company for sharing my/our personal data with State Bank Group entities for specific purpose of availing services offered by State Bank Group(please strike this clause in case you do not wish to disclose the personal data).

Date: DD MM YYYY Place: Signature of the insured: