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.

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

MANIPALCIGNA ACCIDENT SHIELD **CLAIM FORM**

PART I- TO BE COMPLETED BY INSURED PERSON

SECTION A - DETAILS OF POLICY HOLDER

a) Policy No:	
b) Name of Policy Holder: F I R S T N A M E	
c) Address:	
City: State:	Pin Code:
d) Date of Birth (DD/MM/YYYY):	e) Occupation:
f) Telephone Number:	g) Mobile No:

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

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

m Manipal Cigna Health Insurance

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	Funeral Expenses	Permanent Total Disablement
Adventure Sports Cover	Permanent Partial Disablement	EMI Shield
Temporary Total Disablement	Loan Shield	Accidental Hospitalization
Repatriation of Mortal Remains	Child welfare Benefit	Medical Repatriation
Loss of Employment	Cost of crutches/Wheel chairs and artificial limbs	Broken Bones Benefit
Air Ambulance Cover	Coma Benefit	Accidental OPD
Burns Benefit		

SECTION G - CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

Last 3 months Salary Slip/Form 16 for salaried personsLast financial years ITR for self-employed persons

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

In case of A	Accidental Death
Origin	al Death certificate issued by the office of Registrar of Birth & Deaths;
Death	a summary issued by a Hospital;
Post M	Mortem Report (if conducted);
	ty proof of Nominee or Original Succession Certificate/Original Legal Heir Certificate or any other proof to the satisfaction of the any for the purpose of a valid discharge in case nomination is not filed by deceased.
In case of F	Permanent Total Disablement/Partial Disablement/Temporary Total Disablement
Origin	al treating Medical Practitioner's certificate describing the disablement;
Origin	al Discharge summary from the Hospital;
Photo	graph of the Insured Person reflecting the disablement;
Presc	riptions and consultation papers of the treatment;
	ility certificate issued by treating Medical Practitioner (in case of TTD), civil surgeon or equivalent appointed by the District/State or rnment Board.
Any o	ther medical, investigation reports, inpatient or consultation treatment papers, as applicable
In case of T on case to c	TD, We may ask for Disability certificate issued by civil surgeon or equivalent appointed by the District/State or Government Board case basis
Additional	documents required In case of Temporary Total Disablement
Leave	e/Absence Certificate from Employer (If Employed)
Latest	t salary slip or certificate from employer specifying remuneration (in case of salaried Person))
Incom	ne Tax Returns of the previous financial year (in case of self-employed person)
Additional	documents required In case of Accidental Death & Permanent Total Disablement (Common Carrier)
	hal Passenger Ticket / Boarding Pass issued in the name of the Insured Person from the Common Carrier (in case of death in a non carrier). Wherever a named ticket is not available, onus of proof of travel will be upon the Insured Person.
Additional	documents required In case of Hospitalization expenses
Duly c	completed claim form.
Origin	al final hospital bills with itemized break-up and Payment receipts
Disch	arge summary including complete medical history of the patient along with other details
Invest	tigation / Diagnostic test reports etc. supported by the prescription from attending medical practitioner
Sticke	er/Invoice of the Implants, wherever applicable
NEFT	details (to enable direct credit of amount in bank account) and cancelled cheque
KYC ((Identity proof with Address) of the proposer, where claim liability is above Rs1 Lakh as per AML guidelines
Legal	heir / succession certificate, wherever applicable
Child Welfa	are Benefit
Education I	Benefit:
	to establish relationship - Passport/Education certificate establishing proof of relationship of child with parents/Birth Certificate or ion Papers (if adopted).
Photo	Identity Proof of Child (Children)
Age p	proof of Child (Children)
Certifi	icate from Educational Institution describing course details
Death	a certificate of the parent(s)
Orphan Bei	nefit:
Birth (Certificate of child or adoption papers(if adopted)
Photo	Identity Proof of Child (Children)
Age p	proof of Child (Children)
Any o	ther proof to establish relationship – Passport/Education certificate establishing proof of relationship of child with parents.
Legal	Guardian Certificate if the Child is a minor
Death	a certificate of the parent(s)

Los	s of Employment:
	Loss of Employment/Termination/Relieving Letter indicating the reason for loss of Employment.
	Salary Slip of last 3 months
	Last year's Form 16 issued by the employer
	Income Tax Return attested copy.
	Disability certificate issued by civil surgeon or equivalent appointed by the District/State or Government Board
Bro	ken Bones Benefit:
	Original X-Ray/MRI/CT-Scan/Radiology Films/Reports confirming the extent of fracture.
Cor	na Benefit:
	Original Specialist Medical practitioner certificate confirming condition with permanent neurological deficit, and the reason for the same and the duration of comatose stage
	Other documents as specified under the Policy for Coma Benefit
Bur	ns Benefit:
	Original Specialist Medical practitioner certificate confirming degree of burns and total area involved.
Ad	venture Sports Cover:
	Same list of documents like Accidental death or Permanent total disablement.
	Age proof of Insured person.
	Certificate of participation from Sports event organizer/service provider
	Pre participation fitness certificate
	Certificate from the treating doctor mentioning the nature of the Injury
	All Investigation reports
	Discharge summary (If hospitalized)
EM	I / LOAN Shield:
	Latest Loan account statement(s) with NEFT of Financial institution
	Same list of documents as per Accidental Death, Permanent Total Disablement, Permanent Partial Disablement (as applicable)
	Current outstanding Loan certificate(s) from financer, along with the documents submitted
	Loan disbursement letter(s) along with the payment record till the date of Accident
	Repayment schedule showing the EMI details
Rep	patriation of Mortal Remains:
	Original Invoice of expenses.
	Same list of documents as per Accidental Death
Mee	dical Repatriation:
	Original Specialist Medical practitioner certificate confirming the requirement of Medical Repatriation.
	Original Invoice of expenses.
Cos	st of crutches/Wheel chairs and artificial limbs:
	Original Invoice of expenses.
	Original Specialist Medical practitioner prescription advising the same.
Air	Ambulance:
	Original Bill from a certified Ambulance Service Provider or Hospital.
Acc	sidental OPD:
	Complete claim form.
	Photo Identity proof of the patient.
	Medical practitioner's prescription
	Original bills with itemized break-up

Payment receipts

Investigation / Diagnostic test reports etc. supported by the prescription from attending medical practitioner

NEFT details (to enable direct credit of amount in bank account) and cancelled cheque

KYC (Identity proof with Address) of the proposer

(f) Date of Admission: $\square \square \square M M Y Y Y Y$

(h) If claim is related to Temporary Total Disability:

SECTION H - DETAILS OF POLICY HOLDER'S BANK ACCOUNT DETAILS

Please furnish a) Bank Name	h the de	tails	belo	w alo	na	with	con	v of	0.01																									
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b) Bank Brand	ch:																																	
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(g) Date of Discharge: D D M M Y Y Y Y

		imber of days- From Dat			To Date D D	ΛΙΜΙΥΥΥΥΥ
	sume Duties from Date		YY			
		loss of hands/ feet/ eye/ attention to any employn				vent Insured from engaging in o
(ii) If Yes,	, please give details:					
2. Was	the history provided by t	he Insured ('Patient') / of	thers? If 'oth	ers' please furnish de	tails below:	
(a) Name	e and relation with the In	sured:				
3. Has t	the patient been referred	to any other Doctor for	current / ass	sociated ailment? If so	o, please furnish details b	elow:
(a) Name	e and address of the doo	ctor / hospital:				
l hereby knowledg		the Patient in connection	n with the at	pove condition and the	at the facts as given abov	ve are correct to the best of my
	the Doctor:					
	tion Number:					
Qualifica				Specialisation:		
Address:						
Contact I	Number:					
Date: D		Place:		Signa	ature and Seal:	
	of the Company:	he Company				
2 Norma	of the Envelopment					
	of the Employee:					
				Designation:		
5. Please	e provide details of the le	eave availed by the empl	oyee, specif	ying 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	e and Seal of the author	zed signatory of the Cor	npany:			
Name of	the Authorised Signator	y:				
Designat	ion:					
				C :		
Date: D		Place:		Signa	ature and Seal:	

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

	DATA ELEMENT	DESCRIPTION	FORMAT
		SECTION A - DETAILS OF POLICYHOLDER	
<i>'</i>	Policy No.	Enter the policy number	As allotted by the insurance company
<i>'</i>	Name of Policy Holder	Enter the Full Name of the Patient	First Name, Middle Name, Surname
;)	Address	Enter the Full Postal Address	Include Street, City, State and Pin Code
1)	Date of Birth	Enter Date of Birth of Policyholder	Use DD/MM/YYYY format
e)	Occupation	Indicate Occupation of Patient	Please specify the Occupation
)	Telephone Number	Enter the Phone Number of Policyholder	Include STD code with telephone number
)	Mobile No	Enter the Mobile Number of Policyholder	Please enter a 10 digit number
ı)	E-mail Address	Enter E-mail Address of Policyholder	Complete E-mail Address
		Section B - Details of the Insured in respect of whom	
<i>'</i>	Name of Insured Person	Enter the Full Name of the Insured	First Name, Middle Name, Surname
<u> </u>	Address	Enter the Full Postal Address	Include Street, City, State and Pin Code
_	Date of Birth	Enter Date of Birth of Insured	Use DD/MM/YYYY format
)	Occupation	Indicate Occupation of Insured	Please specify the Occupation.
)	Telephone Number	Enter the Phone Number of Insured	Include STD code with telephone number
	Mobile No	Enter the Mobile Number of Insured	Please enter a 10 digit number
)	E-mail	Enter E-mail Address of Insured	Complete E-mail Address
)	Relationship with Policy Holder	Indicate Relationship of Insured with Policyholder	Please specify the relationship
	Date (DD/MM/YYYY) and Time of Injury/ Death	Enter the Date of Injury/ Death	Use DD/MM/YYYY format
)	Place of Accident/ Injury/ Death	Enter the Place where the Accident/ Injury or Death Occurred	Enter Locality, City, State
()	Details and Nature of Accident	Enter details of reason and nature of Accidental Injuries	Describe the nature of Injuries and reason for Accident
)	Did the Accident happen when you were working	Indicate whether the Accident happen when you were working	Tick Yes or No
n)	If Yes, Name and Address of Employer	Indicate the Full Postal Address	Include Street, City, State and Pin Code
ı)	Whether reported to Police	Indicate Whether you have informed and reported to Police	Tick Yes or No
)	If Yes, Name and Address of Police Station	Indicate the Full Postal Address	Include Street, City, State and Pin Code
)	If No, Give reasons	Indicate the reason for Not informing the Police	Indicate the reason for Not informing the Pol
1)	First Information Report (FIR) Number	Indicate the FIR number	Please give complete FIR number
.)	Contact Details of Police Station	Indicate the Telephone number and address of Police station	and Date Include STD code with telephone number/ Address - Include Street, City, State and Pin Code
	N 201 11 11 11	Section C - Details of Hospitalization immediately after	
a)	Name of the Hospital	Indicate the Full Name	Indicate the Full Name
		Indicate the Full Postal Address	Include Street, City, State and Pin Code
)	Address of the Hospital		Lleo DD/MM/XXXX format
;)	Date of Admission	Enter Date of Admission	Use DD/MM/YYYY format
;)	•	Enter Date of Admission Enter Date of Discharge	Use DD/MM/YYYY format
;)	Date of Admission		
;))	Date of Admission	Enter Date of Discharge	
)))	Date of Admission Date of Discharge	Enter Date of Discharge Section D - Details of Witnesses	Use DD/MM/YYYY format
)))	Date of Admission Date of Discharge Was there any witness to the event	Enter Date of Discharge Section D - Details of Witnesses Indicate if there any witness to the event	Use DD/MM/YYYY format Tick Yes or No
))))	Date of Admission Date of Discharge Was there any witness to the event Name	Enter Date of Discharge Section D - Details of Witnesses Indicate if there any witness to the event Enter the Full Name of the Witness	Use DD/MM/YYYY format Tick Yes or No First Name, Middle Name, Surname
))))	Date of Admission Date of Discharge Was there any witness to the event Name Address	Enter Date of Discharge Section D - Details of Witnesses Indicate if there any witness to the event Enter the Full Name of the Witness Enter the Full Postal Address	Use DD/MM/YYYY format Tick Yes or No First Name, Middle Name, Surname Include Street, City, State and Pin Code
))))))	Date of Admission Date of Discharge Was there any witness to the event Name Address Phone Number (Home)	Enter Date of Discharge Section D - Details of Witnesses Indicate if there any witness to the event Enter the Full Name of the Witness Enter the Full Postal Address Enter the Phone Number of Patient	Use DD/MM/YYYY format Tick Yes or No First Name, Middle Name, Surname Include Street, City, State and Pin Code Include STD code with telephone number
))))))	Date of Admission Date of Discharge Was there any witness to the event Name Address Phone Number (Home) Phone Number (Mobile)	Enter Date of Discharge Section D - Details of Witnesses Indicate if there any witness to the event Enter the Full Name of the Witness Enter the Full Postal Address Enter the Phone Number of Patient Enter the Mobile Number of Patient	Use DD/MM/YYYY format Tick Yes or No First Name, Middle Name, Surname Include Street, City, State and Pin Code Include STD code with telephone number Please enter a 10 digit number Include STD code with telephone number
))))))	Date of Admission Date of Discharge Was there any witness to the event Name Address Phone Number (Home) Phone Number (Mobile)	Enter Date of Discharge Section D - Details of Witnesses Indicate if there any witness to the event Enter the Full Name of the Witness Enter the Full Postal Address Enter the Phone Number of Patient Enter the Mobile Number of Patient Enter the Phone Number of Patient	Use DD/MM/YYYY format Tick Yes or No First Name, Middle Name, Surname Include Street, City, State and Pin Code Include STD code with telephone number Please enter a 10 digit number Include STD code with telephone number
)))))))	Date of Admission Date of Discharge Was there any witness to the event Name Address Phone Number (Home) Phone Number (Mobile) Phone Number (Work) Name of the Insurer	Enter Date of Discharge Section D - Details of Witnesses Indicate if there any witness to the event Enter the Full Name of the Witness Enter the Full Postal Address Enter the Phone Number of Patient Enter the Mobile Number of Patient Enter the Phone Number of Patient Indicate Full Name	Use DD/MM/YYYY format Tick Yes or No First Name, Middle Name, Surname Include Street, City, State and Pin Code Include STD code with telephone number Please enter a 10 digit number Include STD code with telephone number Include STD code with telephone number Include STD code with telephone number
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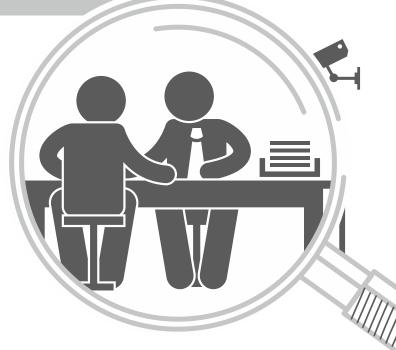


Know Your Customer

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