ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited)
OR Nearest ManipalCigna Branch.
Registered & Corporate Office: 401/402, Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063.
IRDAI Registration No. 151. **Call** (Toll Free): 1800-102-4462 **Visit:** www.manipalcigna.com **E-mail:** servicesupport@manipalcigna.com
CIN: U66000MH2012PLC227948
The issue of this Form is not to be taken as an admission of liability
(To be filled in Block Letters) - PART A - To be filled by Insured

ManipalCigna Health Insurance

5 easy ways to speed up the claims process

1. Submit all original documents as per the checklist within 15 days of discharge from the hospital.
2. Make sure the form is complete and don't forget to sign.
3. Provide correct and accurate bank details with Cancelled cheque
4. For any assistance, please reach out to your health advisor or connect with our Health Relationship Manager.
5. Do not conceal or withhold any information with respect to your claim.

MANIPALCIGNA GROUP OVERSEAS TRAVEL INSURANCE POLICY CLAIM FORM A

SECTION A: DETAILS OF PRIMARY INSURED:

a. Policy Number:

b. Sl. No/Certificate No: c. Company/ TPA ID No:

d. Name:

e. Address:

City: State:

Pin Code: Phone No:

Email ID:

SECTION B: DETAILS OF INSURANCE HISTORY:

a. Currently covered by any Mediclaim/ Health Insurance: Yes ☐ No ☐

b. Date of commencement of first Insurance without break: D D M M Y Y Y Y

c. If Yes, Company Name:

Policy No:

Sum Insured Currency: _____ Amount:

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

Diagnosis:

e. Previously covered by any other Mediclaim/ Health Insurance Yes ☐ No ☐

f. If Yes, Company Name:

SECTION C: DETAILS OF INSURED PERSON IN RESPECT OF WHOM CLAIM IS MADE:

Name:

Gender: Male ☐ Female ☐ Age ☐☐ Years ☐☐ Months ☐☐

Date of Birth: D D M M Y Y Y Y

Relationship to Primary Insured: ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please specify) _____

Occupation: ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student

☐ Retired ☐ Other (Please specify) _____

Address (If different from above):

City: State: Pin code:

Phone No.

Email ID:

SECTION D: DETAILS OF CLAIMED EVENTS:

- ☐ Medical Expenses
- ☐ Life Threatening Pre-Existing Condition Cover
- ☐ Emergency Medical Evacuation
- ☐ Repatriation of Mortal Remains
- ☐ Accidental Death
- ☐ Permanent Total Disablement
- ☐ Permanent Partial Disablement
- ☐ Accidental Death – Common Carrier
- ☐ Permanent Total Disablement – Common Carrier
- ☐ Permanent Partial Disablement – Common Carrier
- ☐ Daily Allowance in case of Hospitalisation
- ☐ Compassionate Visit
- ☐ Pre-Existing Condition Cover for Emergency Care
- ☐ University Excess Medical Cover
- ☐ Home to Home Cover
- ☐ Adventure Sports
- ☐ STD Cover
- ☐ Mental Disorder Cover
- ☐ Substance and Alcohol Abuse
- ☐ Pregnancy Cover
- ☐ Study Interruption
- ☐ Sponsor Protection
- ☐ Alternate Employee/ Substitute Employee Expenses
- ☐ Travel Loan Secure
- ☐ Return of Minor children
- ☐ Emergency Accomodation (Corporate)
- ☐ Any Hospitalisation/ Emergency Care

a. Name of the Hospital where admitted/ availed emergency care

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

c. Emergency Care / Hospitalisation due to ☐ Injury ☐ Illness ☐ Pre-Existing disease ☐ Other: _____

d. Date of Injury / Date of Disease / Medical Condition first detected/ Date of death: D D M M Y Y Y Y

e. Date of Admission D D M M Y Y Y Y f. Time : Hrs

g. Date of Discharge D D M M Y Y Y Y h. Time : Hrs

i. System of Medicine _____

j. Place of Accident / Injury / Death: _____

If Accident,

a. Details of Accident and Nature of Accident: _____

b. Did the Accident happen when you were working: ☐ Yes ☐ No

c. Whether reported to Police: ☐ Yes ☐ No

If Yes, Name and Address of Police Station: _____

If No, Give reasons: _____

d. First Information Report (FIR) / Medico Legal Certificate (MLC) / Missing complaint Number and Date: _____

e. Contact Details of Police Station: _____

If Injury,

a. Give cause: ☐ Self Inflicted ☐ Road Traffic Accident ☐ Substance Abuse/ Alcohol Consumption

b. If Medico legal: ☐ Yes ☐ No

c. Reported to Police: ☐ Yes ☐ No

d. MLC Report & Police FIR Attached: ☐ Yes ☐ No

If Death/ Disability,

a. Cause / Circumstances of death/ disability: _____

b. Details of Common Carrier: _____

k. Details of Sponsor (For Sponsor Protection cover) _____

l. Fees structure: (For Sponsor Protection / Study Interruption Cover) _____

m. Details of Minor Children & Accompanying Adult: (Return of Minor Children Cover) _____

☐ **OPD Expenses** ☐ **Dental Treatment Expenses**

a. Nature of Ailment: _____

b. State Diagnosis and nature of treatment taken: _____

c. Treatment taken: From D D M M Y Y Y Y To: D D M M Y Y Y Y

d. Attending Medical Practitioner's Name & address: _____

_____

e. Have you ever been treated for this illness before? ☐ Yes ☐ No

If Yes, Please provide your physician's name and address: _____

☐ **Loss of Passport**
☐ **Loss of Laptop**
☐ **Loss of Personal Effects**
☐ **Loss of Mobile**
☐ **Debit/ Credit/Forex Card Fraud**
☐ **Financial Emergency Assistance**
☐ **Home Burglary Insurance (Content)**
☐ **Loss of International Driving License**
☐ **Golf Equipment Cover**

a. Description of event: _____

b. Extent of loss (attach item list with amount): _____

c. Details of Police Report: _____

d. Cost incurred in obtaining new passport / IDL (as applicable): _____

e. Date of Purchase of Mobile / Laptop (as applicable): D D M M Y Y Y Y

f. Details of card: _____

☐ **Total Loss of Checked-in Baggage**
☐ **Trip delay**
☐ **Missed Connection**
☐ **Overbooked Flight**
☐ **Delay of Checked-in Baggage**
☐ **Flight Delay**
☐ **Hijack Distress Allowance**
☐ **Cruise Cover**

a. In case of loss, extent of loss: _____

In case of delay, extent of delay: _____

b. Actual Scheduled time: _____ : _____ Hrs D D M M Y Y Y Y

c. Delayed time: _____ : _____ Hrs D D M M Y Y Y Y

d. Reason for denied boarding (if applicable): _____

e. Name of the common carrier: _____

f. Flight and journey details: _____

g. In case of Hijack,

Port of Hijack: _____ Port of release: _____

Date and time of Hijack: _____ : _____ Hrs D D M M Y Y Y Y

h. Date and Time of release _____ : _____ Hrs D D M M Y Y Y Y

☐ **Travel inconvenience cover due to Trip Cancellation and Interruption**

☐ **Trip Curtailment**
☐ **Emergency Accommodation**
☐ **Bounced Hotel Booking**
☐ **Cruise Cover**

a. Flight / Common Carrier Details: _____

b. Scheduled Time: _____ : _____ Hrs D D M M Y Y Y Y

c. Actual Time: _____ : _____ Hrs D D M M Y Y Y Y

d. Reason for delay / cancellation / curtailment / interruption: _____

e. Any other detail: _____

f. Whether accommodation / boarding provided by common carrier? ☐ Yes ☐ No

g. Details of expenses:

Details of expense incurred	Date	Place	Amount
Amount refunded by Common Carrier			
		TOTAL	

☐ **Personal Liability** ☐ **Bail Bond**

☐ **Legal Expenses**

a. Date of incident: D D M M Y Y Y Y

b. Place of incident: _____

c. Details of incident: _____

d. Name of the Third Party: _____

e. Have you received or issued a legal notice? ☐ Yes ☐ No

f. Amount of Liability / Legal expenses / Bail amount (as applicable): _____

Details of expense incurred	Date	Place	Amount
		TOTAL	

☐ **Visa Refusal**

a. Date of visa application: _____

b. Details of application: _____

c. Date of Visa refusal: D D M M Y Y Y Y

d. Reason for Visa refusal: _____

e. Expenses Incurred in Visa application: _____

Details of expense incurred	Date	Place	Amount
		TOTAL	

☐ **Golf Hole in One**

a. Date of game: D D M M Y Y Y Y

b. Details of game: _____

c. Have you been declared winner for a “hole-in-one” at any internationally recognized 18-hole golf course? ☐ Yes ☐ No

d. Expenses Incurred in celebration: _____

Details of expense incurred	Date	Place	Amount
		TOTAL	

☐ **Overseas Travel Service Supplier Insolvency**

a. Date of booking: D D M M Y Y Y Y

b. Details of Service Supplier: _____

c. Date of Service Supplier Insolvency: _____

d. Details of booking done through the service supplier: _____

e. Expenses Incurred: _____

Details of expense incurred	Date	Place	Amount
Amount refunded			
		TOTAL	

SECTION E: DETAILS OF CLAIM

a. Details of Treatment Expenses Claimed:

Hospitalization / Emergency Care Expenses: Currency: ____ Amount

Ambulance Charges Currency: ____ Amount

Others: _____ Currency: ____ Amount

Total: Currency: ____ Amount

b. Details of Lump sum / Cash Benefit Claimed

Daily Allowance in case of Hospitalization Currency: ____ Amount

Others: _____ Currency: ____ Amount

Total: Currency: ____ Amount

c. Details of Other Expenses Claimed

Specify: _____ Currency: ____ Amount

Total: Currency: ____ Amount

Claim Documents Submitted Check List:

☐ Claim Form Duly Signed
☐ Copy of the Claim Intimation, if any
☐ Hospital Main Bill
☐ Hospital Break up Bill
☐ Hospital Bill Payment Receipt
☐ Hospital Discharge Summary
☐ Pharmacy Bill
☐ Operation Theatre Notes
☐ ECG
☐ Doctor's request for Investigation
☐ Investigation Reports (Including CT/MRI/USG/HPE)
☐ Doctors Prescriptions
☐ Others: _____

SECTION F: DETAILS OF BILLS ENCLOSED

Sl. No	Bill No	Date	Issued by	Towards	Amount
1		D D M M Y Y Y Y		Hospital Main Bill	
2		D D M M Y Y Y Y		Pharmacy Bills	
3		D D M M Y Y Y Y			
4		D D M M Y Y Y Y			

SECTION G: DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN: b) Account Number:

c) Bank Name:

d) Branch Name:

e) IFSC Code: f) MICR Code:

g) Cheque / DD Payable Details:

Please attach copy of a cancelled blank cheque of your bank for ensuring accuracy of name of the Bank, Branch name, Account number and IFSC code. If name of the policyholder is not printed on the cheque leaf please attach copy of the first page of the bank passbook also.

SECTION H: DECLARATION BY 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.

"I/we hereby give my/our consent to the Company/its authorized representatives to access/download/verify/register/update my/our KYC documents on/from the Central KYC Registry or through any other modes for the purpose of KYC."

Date: D D M M Y Y Y Y Place: Signature of the Insured:

SECTION I: TO BE FILLED BY NOMINEE / LEGAL HEIR (IN THE EVENT OF INSURED PERSON'S DEATH)

Name of Nominee:

Address:

City: State: Pin Code:

Date of Birth: D D M M Y Y Y Y

Relationship with the Deceased:

Telephone Number: Mobile Number:

Email ID:

DECLARATION BY NOMINEE (IN THE EVENT OF INSURED PERSON'S DEATH):

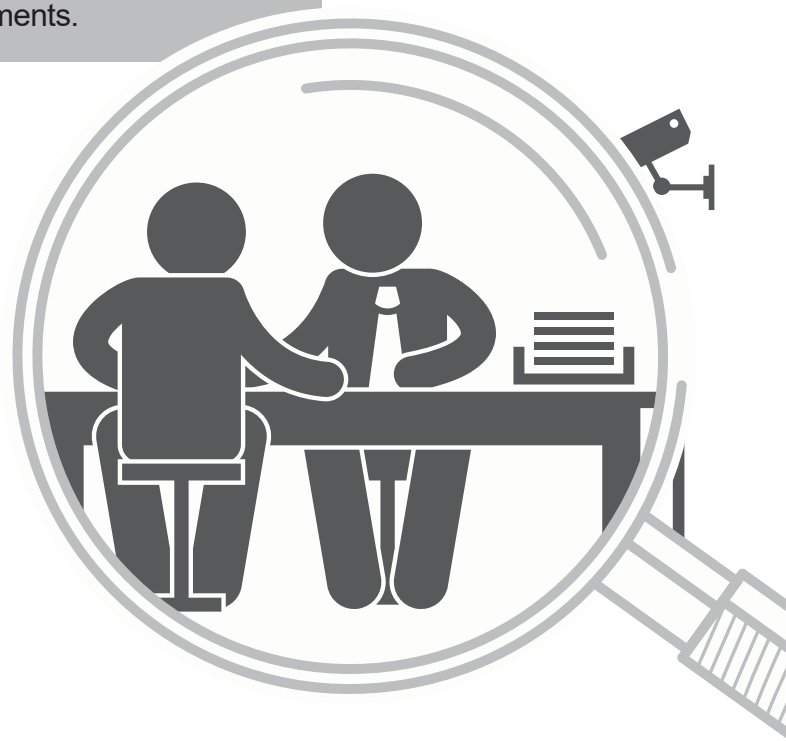
I/We hereby declare that the foregoing particulars are true & correct to the best of my knowledge and belief. I also authorize Insurance Company to make payment of the claim admissible as per terms, conditions and limitations to the Insured person or his legal heir as full and final settlement. I/We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

Date: D D M M Y Y Y Y Place: Signature:

ManipalCigna Health Insurance

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 duringpolicyissuance. **YES** ☐ **NO** ☐

Weshallusebelowmentioned information from the policy for payment of your claim:

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

ManipalCigna Group Overseas Travel Insurance Policy | UIN: CTTTGOP19019V011819 | March 2025