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

ManipalCigna Health Insurance

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

5 easy ways to speed up the claims process

1. Submit all original documents as per the checklist within 90 days of date of diagnosis or occurrence of event.
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 LIFESTYLE PROTECTION GROUP POLICY
GROUP CRITICAL ILLNESS BASIC COVERS CLAIM FORM

SECTION I- TO BE COMPLETED BY INSURED PERSON/ CLAIMANT

A: DETAILS OF POLICY HOLDER

a) Corporate Name: b) Policy No.:

c) Name: FIRST NAME MIDDLE NAME LASTNAME

d) Address:

City: State: Pin Code:

e) Date of Birth: DD MM YYYY f) Occupation:

g) Phone No.: h) Mobile No.:

I) E-mail ID:

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) Occupation:

e) Telephone Number: f) Mobile No:

g) Email:

h) Relationship with Policy Holder:

i) Name of Critical illness Diagnosed:

j) Date of First Consultation: DD MM YYYY

C. DETAILS OF HOSPITALIZATION

a) Were you hospitalized for the present illness: **Yes** ☐ **No** ☐ (If Yes, give the following)

b) Name and Address of the Hospital:

c) Date of Admission: DD MM YYYY d) Time: HH : MM

e) Date of Discharge: DD MM YYYY f) Time: HH : MM

D. DETAILS OF ANY OTHER HEALTH INSURANCE POLICY

a) Do you have any other health insurance policy: **Yes** ☐ **No** ☐ (If Yes, complete the following)

b) Name & Address of the Insurer and Issuing office: _____

c) Policy Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

d) Policy Period: ☐☐☐☐☐☐☐☐☐☐☐☐ e) Sum Insured: ☐☐☐☐☐☐☐☐☐☐☐☐☐

E. DETAILS OF BENEFITS CLAIMED

Critical illness Benefit: Rs. ☐☐☐☐☐☐☐☐☐☐☐☐

Please tick against the Critical Illness that the Insured Person has been diagnosed:

☐ 1. Cancer of specific severity	☐ 19. End Stage Liver Failure
☐ 2. First Heart Attack - of Specific Severity	☐ 20. Major Burns
☐ 3. Open Chest CABG	☐ 21. Fulminant Hepatitis
☐ 4. Open Heart Replacement or Repair of Heart Valves	☐ 22. Alzheimer's Disease
☐ 5. Coma of Specified Severity	☐ 23. Bacterial Meningitis
☐ 6. Kidney Failure Requiring Regular Dialysis	☐ 24. Benign Brain Tumor
☐ 7. Stroke Resulting in Permanent Symptoms	☐ 25. Apallic Syndrome
☐ 8. Major Organ / Bone Marrow Transplant	☐ 26. Parkinson's Disease
☐ 9. Permanent Paralysis of Limbs	☐ 27. Medullary Cystic Disease
☐ 10. Motor Neurone Disease with Permanent Symptoms	☐ 28. Muscular Dystrophy
☐ 11. Multiple Sclerosis with Persisting Symptoms	☐ 29. Loss of Speech
☐ 12. Primary Pulmonary Hypertension	☐ 30. Systemic Lupus Erythematous
☐ 13. Aorta Graft Surgery	☐ 31. Loss of Limbs
☐ 14. Loss of Hearing	☐ 32. Major Head Trauma
☐ 15. Loss of Sight	☐ 33. Brain Surgery
☐ 16. Aplastic Anaemia	☐ 34. Cardiomyopathy
☐ 17. Coronary Artery Disease	☐ 35. Creutzfeldt-Jacob Disease (CJD)
☐ 18. End Stage Lung Disease	☐ 36. Terminal Illness

F. CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

- ☐ Duly completed and signed claim form in original as prescribed by Us.
- ☐ Medical Certificate confirming the diagnosis of critical illness
- ☐ Certificate from attending Medical Practitioner confirming that the claim does not relate to any Pre-existing Illness or Injury or any Illness or Injury which was diagnosed within the first 90 days of the Inception of the Policy.
- ☐ Discharge Certificate/ Card from the hospital, if any
- ☐ Investigation test reports confirming the diagnosis,
- ☐ First consultation letter and subsequent prescriptions
- ☐ Indoor case papers if applicable
- ☐ KYC Documents

Please submit the following documents in case of claim amount exceeds Rs. 100,000 (as per KYC norms of IRDAI):

a. **Proof of Identity** (Any one of the mentioned documents)

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/ Letter from a recognized public authority verifying the identity of the customer.

b. **Proof of Residence** (Any one of the mentioned documents)

Telephone bill/ Attested current statement of Bank account details/ Letter from any recognized public authority/ Electricity bill provided it is not older than six months from the date of insurance contract / Ration card

G. DETAILS OF POLICY HOLDER'S BANK ACCOUNT

Please furnish the details below along with copy of cancelled cheque.

Bank Name:

Bank Branch:

Bank Account Number:

IFSC Code: MICR Code:

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 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/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 II: TO BE FILLED BY NOMINEE (IN THE EVENT OF POLICY HOLDER'S DEATH)

Name of Nominee:

Address:

Date of Birth: D D M M Y Y Y Y Relationship with the Deceased:

Telephone Number: Mobile Number:

Email:

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 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:

SECTION III: TO BE FILLED BY TREATING DOCTOR WHO ATTENDED THE INSURED

Name of the Insured ('Patient'):

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

1. Are you the patient's usual medical attendant? **Yes** **No**

a. If Yes, since when? D D M M Y Y Y Y

b. If you have treated him/her for any previous illness or injury, please give details:

2. Details of the consultation by the Patient for present injury.

a. Date of first consultation: D D M M Y Y Y Y

b. Presenting Complaints:

c. Nature of Injury:

d. History reported:

e. Extent of Injury:

f. Diagnosis:

g. Treatment given:

h. If hospitalized:

Date of Admission: D D M M Y Y Y Y Time of Admission: H H M M

Date of Discharge: D D M M Y Y Y Y Time of Discharge: H H M M

3. Has the patient sustained a similar injury previously or aggravated a pre-existing condition? **Yes** **No**

If Yes, please give details:

4. If due to Accident, then cause of Present Injury

Self-Inflicted Road Traffic Accident Substance Abuse/ Alcohol abuse Other:

Please provide details of cause of injury:

5. Is the cause traceable to any disease, previous injuries: **Yes** **No**

If Yes, please give details:

6. Has the present illness resulted in permanent neurological deficit: **Yes** **No**

If Yes, please provide duration: _____ months

7. Will the present illness require any major organ/ bone marrow transplant: **Yes** **No**

If Yes, please provide details:

8. Has the present illness resulted in loss of speech/loss of hearing/loss of sight: **Yes** **No**

If Yes, please provide details with duration:

Is this loss irreversible: **Yes** **No**

9. In case of injury due to major burns:

a. Nature and Extent of Burns Injury:

b. Percentage of surface area of Burns:

10. Has the present condition resulted in inability to perform following daily activities:

Washing: **Yes** **No** Dressing: **Yes** **No**

Transferring: **Yes** **No** Toileting: **Yes** **No**

Feeding: **Yes** **No** Mobility: **Yes** **No**

11. Has the present illness resulted in deterioration of intellectual/ social functioning and require continuous supervision of the insured person:

Yes **No**

12. In case of Coma:

Please specify the cause and severity of coma:

Are life support measures necessary to sustain life:

Extent of neurological deficit:

13. In case of cardiac impairment:

a. Are the symptoms of chest discomfort present at rest: **Yes** **No**

b. Is the Insured person able to engage in activities without physical discomfort: **Yes** ☐ **No** ☐

c. Has the present illness resulted in permanent cardiac impairment: **Yes** ☐ **No** ☐

d. Please provide the degree of cardiac impairment: _____

14. Was the history provided by the Insured ('Patient') / others? If 'others' please furnish details below:

Name and relation with the Insured: _____

15. Has the patient been referred to any other Doctor for current / associated ailment? If so, please furnish details below:

1. Name and address of the doctor / hospital: _____

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

Registration Number: Qualification:

Specialization _____

Address _____

Contact Number

Date: D D M M Y Y Y Y Place: Seal and Signature of the Doctor:

GUIDANCE FOR FILLING CLAIM FORM - (To be filled in by the Insured/ claimant)

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION I- TO BE COMPLETED BY INSURED PERSON		
A. Details of Policy Holder:		
a. Name of Corporate	Enter the company name	Free Text
b. Policy Number	Enter the policy number	As allotted by the insurance company
c. Name of Policy Holder	Enter the Full Name of the Policy Holder	First Name, Middle Name, Surname
d. Address	Enter the Full Postal Address	Include Street, City, State and Pin Code
e. Date of Birth (DD/MM/YYYY)	Enter Date of Birth of Policyholder	Use DD/MM/YYYY format
f. Occupation	Indicate Occupation of Policy Holder	Please specify the Occupation
g. Telephone Number	Enter the Phone Number of Policyholder	Include STD code with telephone number
h. Mobile No	Enter the Mobile Number of Policyholder	Please enter a 10 digit number
i. Email	Enter E-mail Address of Policyholder	Complete E-mail Address
B. Details of the Insured in respect of whom claim is made		
a. Name of Insured Person	Enter the Full Name of the Insured	First Name, Middle Name, Surname
b. Address	Enter the Full Postal Address	Include Street, City, State and Pin Code
c. Date of Birth (DD/MM/YYYY)	Enter Date of Birth of Insured	Use DD/MM/YYYY format
d. Occupation	Indicate Occupation of Insured	Please specify the Occupation.
e. Telephone Number	Enter the Phone Number of Insured	Include STD code with telephone number
f. Mobile No	Enter the Mobile Number of Insured	Please enter a 10 digit number
g. Email	Enter E-mail Address of Insured	Complete E-mail Address
h. Relationship with Policy Holder	Indicate Relationship of Insured with Policyholder	Please specify the relationship
i. Name of Critical illness Diagnosed	Enter the Nature of Disease contracted	Enter the symptoms/diagnosis of the disease/injury
j. Date of First Consultation	Indicate date when you first consulted for the present illness	Enter date when first consulted for present illness
C. Details of Hospitalization immediately after the accident		
a. Were you hospitalized immediately after the accident	Indicate if you were hospitalized after accident	Select Yes or No
b. Name and Address of the Hospital	Indicate the Full Name and Postal Address	Indicate the Full Name of Hospital Include Street, City, State and Pin Code
c. Date of Admission	Enter Date of Admission	Use DD/MM/YYYY format
Time of Admission	Enter Time of Admission	Use HH:MM format
d. Date of Discharge	Enter Date of Discharge	Use DD/MM/YYYY format
Time of Discharge	Enter Time of Discharge	Use HH:MM format
D. Details of any other Health Insurance Policy		
a. Do you have any other health insurance policy	Indicate whether you have any other personal	Select Yes or No accident insurance policy
b. Name & Address of the Insurer and Issuing office	Enter the Name of Insurance Company and Policy Issuing Office	Free Text
c. Policy Number	Enter the Policy Number	As allotted by Insurance Company
d. Policy Period	Enter the Policy Period	As mentioned in the Policy schedule
e. Sum Insured	Enter the Sum Insured	Enter the Sum Insured
Please Indicate and Tick the Benefits claimed		
E. Details of Benefits Claimed		
Please Indicate the Sum Insured amount and Tick the Benefits claimed		
F. Check List of Enclosures for Submission of Claim		
Indicate documents are enclosed		
G. Details of Policy Holder's Bank Account		
Bank Name	Enter the Bank Name	Name of the Bank in full
Bank Branch	Enter Name of the Branch	Name of the Branch
Bank Account Number	Enter the Bank Account Number	As allotted by the Bank
IFSC Code	Enter the IFSC Code of the Bank Branch	IFSC Code of the Bank Branch in full
MICR Code	Enter the MICR Code	MICR Code of the Bank Branch in full
H. Declaration by the Insured		
Read Declaration carefully and mention date (in DD/MM/YYYY format), place (open text) and sign.		