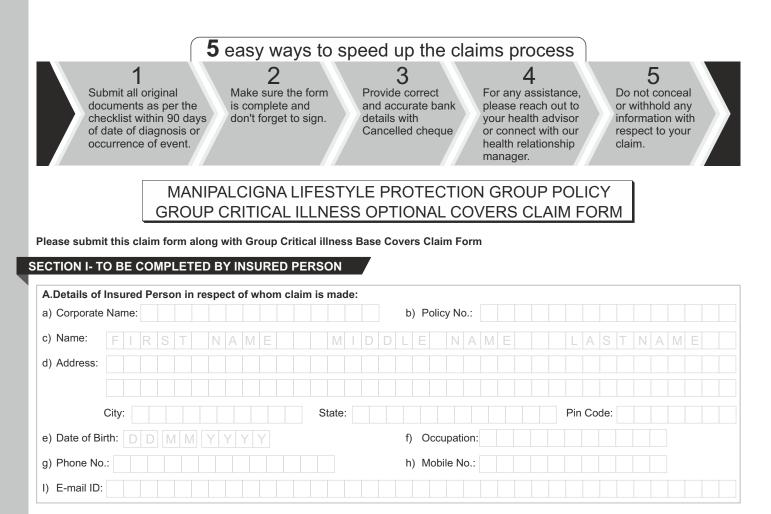
ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited) OR Nearest ManipalCigna Branch. Registered & Corporate Office: 401/402, Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063. IRDAI Registration No. 151. Call (Toll Free): 1800-102-4462 Visit: www.manipalcigna.com E-mail: servicesupport@manipalcigna.com

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



B. DETAILS OF OPTIONAL COVERS CLAIMED:

Benefit			Amount										
	1	Survival Period Waiver											
2	2	Emergency Road Ambulance Benefit											
3	3	Emergency Evacuation											
4	4	Medical Repatriation											
Ę	5	Marriage Benefit for Dependent Children											
6	6	Education Fund Benefit											
7	7	Convalescence Benefit											
8	8	Hospital Cash Benefit											
ç	9	Rehabilitation Benefit											
	10	Loss of Earning Benefit											
	11	Family Counseling Benefit											
	12	Family Transportation Allowance Benefit											
	13	Medical Second Opinion											
	14	Wellness Benefit											

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Health Insurance

C. DETAILS OF THE INSURED IN RESPECT OF OPTIONAL COVERS (to be filled by claimant wherever applicable):

1	Survival Period Waiver
	Have you opted for waiver of survival period? Yes No
2	Emergency Road Ambulance Benefit
	Ambulance Charges:
3	Emergency Evacuation
a.	Location from which evacuation has to be conducted:
b.	Location to which evacuation has to be conducted:
4	Medical Repatriation
a.	Location from which repatriation has to be conducted:
b.	Location to which repatriation has to be conducted:
5	Marriage Benefit for Dependent Children
a.	No of Children:
b.	Date of Birth of Child/ Children: D D M M Y Y Y Y
6	Education Fund Benefit
a.	Name of Child/ Children:
b.	Tuition Fees paid for the current academic year:
7	Convalescence Benefit
a.	Date of hospitalisation: D D M M Y Y Y Y
b.	Date of Discharge: D D M M Y Y Y Y
C.	Diagnosis as per Discharge card:
8	Hospital Cash Benefit
a.	Date of hospitalisation: D D M M Y Y Y Y
b.	Date of Discharge: D D M M Y Y Y Y
C.	Diagnosis as per Discharge card:
9	Rehabilitation Benefit
a.	Services availed: Specialist Consultation Extended Physiotherapy
b.	Cost incurred:
10	Loss of Earning Benefit
a.	Total monthly income last drawn:
11	Family Counseling Benefit
a.	Details of prescribed Counseling:
b.	Expense incurred for Counseling:
12	Family Transportation Allowance Benefit
a.	Travelled: From D D M Y Y Y To D D M M Y Y Y
b.	Mode of Transport:
C.	Expenses incurred for Travelling:
13	Medical Second Opinion
a.	Place of illness/Injury:
b.	Details of illness and Nature of illness:
C.	Current Diagnosis:
14	Wellness Benefit
a.	Expenses incurred for Diagnostic Test:

Emergency Road Ambulance Benefit	Original invoice of actual expenses incurred towards Ambulance
Marriage Benefit for Dependent Children	Proof of relationship with the Insured and Age proof of the dependent child
Education Fund Benefit	Proof of expenses incurred towards tuition fees as a full time student at an accredite educational institution and Age proof of the dependent child
Convalescence	Original copies of Hospital bills, receipts, prescriptions and invoices
Hospital Cash Benefit	
Rehabilitation Benefit	Original invoice of counseling by a professional counselor/ Physiotherapist
Loss of Earning Benefit	In case of salaried Insured Persons, Last 3 month's salary slips of the previous employer of the Insured Person.
	In case of self-employed Insured Persons, Last income tax returns filed by the Insur Person with the income tax department.
Family Counseling Benefit	Original invoice of counseling by a professional counselor
Family Transportation Allowance Benefit	Original invoice of travel expense incurred

E. 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.



Place:

Signature of the Insured: