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 OPTIONAL COVERS CLAIM FORM

Please submit this claim form along with Group Critical illness Base Covers Claim Form

SECTION I- TO BE COMPLETED BY INSURED PERSON

A.Details of Insured Person in respect of whom claim is made:

a) Corporate Name: b) Policy No.:

c) Name: FIRST NAME MIDDLE NAME LAST NAME

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 OPTIONAL COVERS CLAIMED:

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

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 M Y Y Y Y To D D M M Y 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: ______

D. CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM: (In addition to the documents listed under specific section of Base Covers Opted)

☐ 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 accredited 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 Insured 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.

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