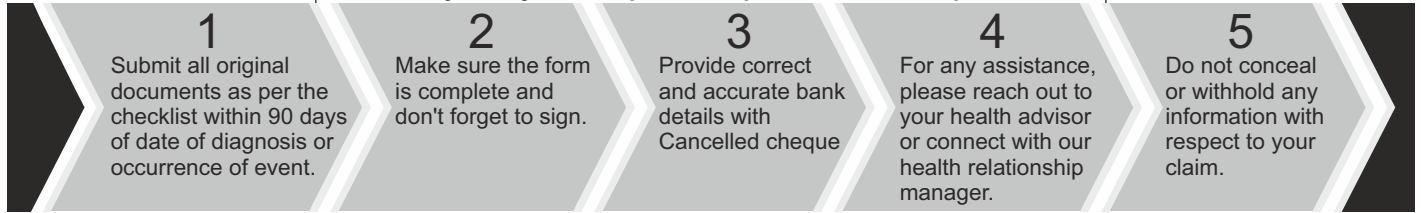


The issue of this Form is not to be taken as an admission of liability
 (To be filled in Block Letters) - PART A - To be filled by Insured

5 easy ways to speed up the claims process



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:	<input type="text"/>	b) Policy No.:	<input type="text"/>
c) Name:	<input type="text"/> F <input type="text"/> I <input type="text"/> R <input type="text"/> S <input type="text"/> T <input type="text"/> N <input type="text"/> A <input type="text"/> M <input type="text"/> E <input type="text"/> M <input type="text"/> I <input type="text"/> D <input type="text"/> D <input type="text"/> L <input type="text"/> E <input type="text"/> N <input type="text"/> A <input type="text"/> M <input type="text"/> E <input type="text"/> L <input type="text"/> A <input type="text"/> S <input type="text"/> T <input type="text"/> N <input type="text"/> A <input type="text"/> M <input type="text"/> E		
d) Address:	<input type="text"/>		
	<input type="text"/>		
City:	<input type="text"/>	State:	<input type="text"/>
		Pin Code:	<input type="text"/>
e) Date of Birth:	<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y	f) Occupation:	<input type="text"/>
g) Phone No.:	<input type="text"/>	h) Mobile No.:	<input type="text"/>
i) E-mail ID:	<input type="text"/>		

B. DETAILS OF OPTIONAL COVERS CLAIMED:

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

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

[illegible]

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

<input type="checkbox"/> Emergency Road Ambulance Benefit	Original invoice of actual expenses incurred towards Ambulance
<input type="checkbox"/> Marriage Benefit for Dependent Children	Proof of relationship with the Insured and Age proof of the dependent child
<input type="checkbox"/> 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
<input type="checkbox"/> Convalescence	Original copies of Hospital bills, receipts, prescriptions and invoices
<input type="checkbox"/> Hospital Cash Benefit	
<input type="checkbox"/> Rehabilitation Benefit	Original invoice of counseling by a professional counselor/ Physiotherapist
<input type="checkbox"/> 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.
<input type="checkbox"/> Family Counseling Benefit	Original invoice of counseling by a professional counselor
<input type="checkbox"/> 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: Place: Signature of the Insured: