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:** customercare@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 thechecklist within 30 days of 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 PERSONAL ACCIDENT 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 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 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) Date: DD MM YYYY Time of Injury/Death: : hrs.

j) Place of Accident/Injury/Death:

k) Details of Accident and Nature of Accident:

l) Did the Accident happen when you were working: Yes ☐ No ☐ m) Whether reported to Police: Yes ☐ No ☐

If Yes, Name and Address of Police Station:

If No, Give reasons:

n) First Information Report (FIR)/ Medico Legal Certificate (MLC)/ Missing complaint

No. Date: DD MM YYYY

o) Contact Details of Police Station:

C.DETAILS OF HOSPITALIZATION IMMEDIATELY AFTER THE ACCIDENT

a) Were you hospitalized immediately after the accident: **Yes** ☐ **No** ☐ (If Yes, give the following)

b) Name and Address of the Hospital: _____

c) Date of Admission: D D M M Y Y Y Y d) Time: H H : M M

e) Date of Discharge: D D M M Y Y Y Y f) Time: H H : M M

D.DETAILS OF WITNESSES

a) Was there any witness to the event: **Yes** ☐ **No** ☐ (If Yes, complete the following)

b) Name: _____

c) Address: _____

d) Pin code: _____ e) Place of Witness: _____

f) Phone Number (Work): _____ g) Phone Number (Mobile): _____

Please attach all original witness statements if already obtained.

E. DETAILS OF ANY OTHER PERSONAL ACCIDENT POLICY

a) Do you have any other personal accident policy: **Yes** ☐ **No** ☐ (If Yes, give the following)

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

c) Policy Number: _____

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

F. DETAILS OF BENEFITS CLAIMED:

Benefit	**Amount**
☐ Accidental Death	
☐ Permanent Total Disablement	
☐ Permanent Partial Disablement	
☐ Temporary Total Disablement	
Total claimed Amount	

G. CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

Documents required for all Claims:

- ☐ Photo Identity Proof - Voter ID, Passport, PAN Card, Driving License, Ration Card, Aadhar, or any other proof accepted by the KYC norms as approved by Us and which is admissible in court of law
- ☐ Duly completed and signed claim form in original as prescribed by Us
- ☐ Copy of FIR/ Panchnama /Police Inquest Report (if conducted) duly attested by the concerned Police Station
- ☐ Copy of Medico Legal Certificate(if conducted) duly attested by the concerned Hospital

1. In case of Accidental Death Benefit:

- ☐ Original Death certificate issued by the office of Registrar of Birth & Deaths
- ☐ Copy of Post Mortem report, if conducted
- ☐ Copy of chemical analysis / Forensic report, if applicable
- ☐ Death Summary, if death in Hospital
- ☐ Copies of Medical records, investigation reports, if admitted to hospital
- ☐ Identity proof of Nominee or Original Succession Certificate/Original Legal Heir Certificate or any other proof to Our satisfaction for the purpose of a valid discharge in case nomination is not filed by deceased.

2. In case of Permanent Total Disability/ Permanent Partial Disablement Benefit

- ☐ Disability certificate issued by a civil surgeon or the equivalent appointed by the District, State or Government Board (or) certificate from the treating doctor certifying the extent of disability
- ☐ Original treating Medical Practitioner's certificate describing the disablement;
- ☐ Original Discharge summary from the Hospital;
- ☐ Photograph of the Insured Person reflecting the disablement;
- ☐ Copies of Medical records, investigation reports, if admitted to hospital

3. In case of Temporary Total Disablement Benefit(in addition to 2 above)

- ☐ Leave/ Absence Certificate from Employer in case of salaried employees
- ☐ Latest Salary slip or certificate from employer specifying the remuneration, in case of salaried employees

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

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

H. 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:

I. 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:

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) 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) Are Injuries sustained in this accident the sole cause of disablement: **Yes** **No**

7) Please specify the number of days when the injured person is advised rest/unfit and should be confined to bed/house as the direct and sole consequence of the injury sustained

From: D D M M Y Y Y Y To: D D M M Y Y Y Y

a. Will the Injured person be able to attend to his/her normal duties? **Yes** **No**

b. If Yes, from what date: D D M M Y Y Y Y

8) Has the accident resulted into loss of hands/ feet/ eye/s or permanent disability of any other type which may prevent Insured from engaging in or being occupied with or giving attention to any employment or occupation whatsoever? **Yes** **No**

If Yes, please give details:

9) Is the injured person suffering from any disease or illness apart from his injury which may tend to retard recovery? **Yes** **No**

If Yes: Give particulars:

10) Was he/she under the influence of alcohol/intoxicants or drugs at the time of accident? **Yes** **No**

11) Nature of disablement:

a. Permanent Total Disablement **Yes** **No**

b. Permanent Partial Disablement **Yes** **No**

c. Please specify percentage: %

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

a. Name and relation with the Insured:

13) 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:

SECTION IV: TO BE FILLED BY EMPLOYER

1. Name of the Company:
2. Address & Contact Details of the Company:
3. Name of the Employee:
4. Date of Joining Service: D D M M Y Y Y Y 5. Designation:
6. Please provide details of the leave availed by the employee, specifying the type of leave.

Sr. No.	Date from which leave is taken	Date when resumed duties	No. of Days	Type of Leave	In case of Sickness Leave, medical certificate produced- Yes/ No	Reason for Leave

Name of the Authorised Signatory:

Designation:

Date: D D M M Y Y Y Y Place: Signature and Seal of the authorized signatory of the Company:

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. Date (DD/MM/YYYY) and Time of Injury/Death	Enter the Date and Time of Injury/Death as the case may be	Use DD/MM/YYYY format Use HH:MM format
j. Place of Accident/Injury/Death	Indicate the place of accident/Injury/death as applicable	Enter the place
k. Details of Accident and Nature of Accident	Enter the complete details and narration of accident	Free Text
l. Did the Accident happen when you were working	Indicate whether accident happen while working	Select Yes or No
m. Whether reported to Police	Indicate whether the accident was reported to Police	Select Yes or No If Yes, then provide Name and Address of Police Station, If No, then give reasons for the same.
n. First Information Report (FIR)/ Medico Legal Certificate (MLC)/ Missing complaint Number and Date	Enter the FIR/MLC/Missing complaint number	As allotted by police station/hospital
o. Contact Details of Police Station	Enter the contact details of police station where accidental case if filed	Please enter the name of police station and landline number of police station
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 Witnesses		
a. Was there any witness to the event	Indicate whether there was any witness to the event	Select Yes or No
b. Name	Enter the Full Name of Witness	First Name, Middle Name, Last Name
c. Address	Enter the Full Postal Address	Include Street, City, State and Pin Code
d. Pin code	Enter the Pin Code	Indicate the Pin Code
e. Place of Witness	Indicate the Place of Witness	Enter the Place of Witness
f. Phone Number(Work)	Enter the Phone Number of Insured	Include STD code with telephone number
g. Phone Number(Mobile)	Enter the Mobile Number of Insured	Please enter a 10 digit number
E. Details of any other personal accident policy		
a. Do you have any other personal accident policy	Indicate whether you have any other personal accident insurance policy	Select Yes or No
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

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

DATA ELEMENT	DESCRIPTION	FORMAT
F. Details of Benefits Claimed		
Please Indicate the Sum Insured amount and Tick the Benefits claimed		
G. Check List of Enclosures for Submission of Claim		
Indicate documents are enclosed		
H. 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
I. Declaration by the Insured		
Read Declaration carefully and mention date (in DD/MM/YYYY format), place (open text) and sign.		