Please return your completed claim form to:
ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited)
OR Nearest ManipalCigna Branch.
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

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

ManipalCigna Health Insurance

SARAL SURAKSHA BIMA, MANIPALCIGNA CLAIM FORM

PART I- TO BE COMPLETED BY INSURED PERSON

SECTION A - DETAILS OF POLICY HOLDER

a) Policy No:

b) Name of Policy Holder: FIRST NAME MIDDLE NAME SURNAME

c) Address:

City: State: Pin Code:

d) Date of Birth (DD/MM/YYYY): DD MM YYYY e) Occupation:

f) Telephone Number: g) Mobile No:

h) Email:

SECTION B - DETAILS OF THE INSURED IN RESPECT OF WHOM CLAIM IS MADE

a) Name of Insured Person: FIRST NAME MIDDLE NAME SURNAME

b) Address:

City: State: Pin Code:

c) Date of Birth (DD/MM/YYYY): DD MM YYYY d) Occupation:

e) Telephone Number: f) Mobile No:

g) Email:

h) Relationship with Policy Holder:

i) Date (DD/MM/YYYY) and Time of Injury/Death: DD MM YYYY : :

j) Place of Accident/ Injury/ Death:

k) Details and Nature of Accident:

l) Did the Accident happen when you were working: Yes ☐ No ☐

m) If Yes, Name and Address of Employer:

n) Whether reported to Police: Yes ☐ No ☐

o) If Yes, Name and Address of Police Station:

p) If No, Give reasons:

q) First Information Report (FIR) Number and Date: DD MM YYYY

r) Contact Details of Police Station:

SECTION C - DETAILS OF HOSPITALIZATION IMMEDIATELY AFTER THE ACCIDENT

Yes ☐ No ☐ (If Yes, please give the following)

a) Name of the Hospital:

b) Address of Hospital:

c) Date of Admission: D D M M Y Y Y Y d) Date of Discharge: D D M M Y Y Y Y

SECTION D - DETAILS OF WITNESSES

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

b) Name:

c) Address:

City: State: Pin Code:

Place of Witness:

d) Phone Number (Home): e) Phone Number (Mobile):

f) Phone Number (Work):

SECTION E - DETAILS OF ANY OTHER PERSONAL ACCIDENT POLICY

Yes ☐ No ☐ (If Yes, complete the following)

a) Name of the Insurer:

b) Address of the Issuing office:

City: State: Pin Code:

c) Policy Number:

d) Policy Period: e) Sum Insured:

SECTION F - DETAILS OF BENEFITS CLAIMED

Accidental Death	☐	Permanent Total Disablement	☐
Permanent Partial Disablement	☐	Temporary Total Disablement	☐
Education Grant	☐	Hospitalization Expenses due to Accident	☐

SECTION 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 the Company 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,
- ☐ Income Proof
- ☐ - Last 3 months Salary Slip/Form 16 for salaried persons
- ☐ - Last financial years ITR for self-employed persons

In case of Accidental Death

- ☐ Original Death certificate issued by the office of Registrar of Birth & Deaths;
- ☐ Death summary issued by a Hospital;
- ☐ Post Mortem Report (if conducted);
- ☐ Identity proof of Nominee or Original Succession Certificate/Original Legal Heir Certificate or any other proof to the satisfaction of the Company for the purpose of a valid discharge in case nomination is not filed by deceased.

In case of Permanent Total Disablement/Partial Disablement/Temporary Total Disablement

- ☐ Original treating Medical Practitioner's certificate describing the disablement;
- ☐ Original Discharge summary from the Hospital;
- ☐ Photograph of the Insured Person reflecting the disablement;
- ☐ Prescriptions and consultation papers of the treatment; Disability certificate issued by civil surgeon or equivalent appointed by the District/State or Government Board.
- ☐ Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable

Additional documents required In case of Temporary Total Disablement

- ☐ Leave/Absence Certificate from Employer (If Employed)

Additional documents required In case of Hospitalization expenses

- ☐ Duly completed claim form.
- ☐ Original final hospital bills with itemized break-up and Payment receipts
- ☐ Discharge summary including complete medical history of the patient along with other details
- ☐ Investigation / Diagnostic test reports etc. supported by the prescription from attending medical practitioner
- ☐ Sticker/Invoice of the Implants, wherever applicable
- ☐ NEFT details (to enable direct credit of amount in bank account) and cancelled cheque
- ☐ KYC (Identity proof with Address) of the proposer, where claim liability is above Rs1 Lakh as per AML guidelines
- ☐ Legal heir / succession certificate, wherever applicable

Education Grant:

- ☐ Proof to establish relationship - Passport/Education certificate establishing proof of relationship of child with parents/Birth Certificate or Adoption Papers (if adopted).
- ☐ Photo Identity Proof of Child (Children)
- ☐ Age proof of Child (Children)
- ☐ Certificate from Educational Institution describing course details

SECTION H - DETAILS OF POLICY HOLDER'S BANK ACCOUNT DETAILS

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

a) Bank Name:

b) Bank Branch:

c) Bank Account Number:

d) IFSC Code: e) MICR Code:

SECTION 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 Cigna TTK Health Insurance Company Ltd. 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:

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

Name of Nominee: FIRST NAME MIDDLE NAME SURNAME

Address:

City: State: Pin Code:

Date of Birth: DD MM YYYY Relationship with the Deceased:

Telephone Number: Mobile No:

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 Cigna TTK Health Insurance Company Ltd. 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 Cigna TTK Health Insurance Company Ltd. harmless from any claim under this policy by any third party.

Date: DD MM YYYY Place: Signature of the Nominee:

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

Name of the Insured ('Patient') : Age:

1. Details of the consultation by the Patient

(a) Date of consultation: DD MM YYYY

(b) Presenting Complaints:

(c) Nature of Injury: History reported by

(d) Diagnosis:

(e) Treatment given:

(f) Date of Admission: DD MM YYYY (g) Date of Discharge: DD MM YYYY

(h) If claim is related to Temporary Total Disability:

Advised rest/unfit for specified number of days- From Date DD MM YYYY To Date DD MM YYYY

Fit to Resume Duties from Date DD MM YYYY

(i) 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**

(ii) If Yes, please give details:

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

(a) Name and relation with the Insured:

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

(a) 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: Specialisation:

Address:

Contact Number:

Date: DD MM YYYY Place: Signature and Seal:

PART IV: TO BE FILLED BY EMPLOYER (IN CASE, INSURED IS EMPLOYED)

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 Designation: _____

5. 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

Signature and Seal of the authorized signatory of the Company:

Name of the Authorised Signatory: _____

Designation: _____

Date: D D M M Y Y Y Y Place: _____ Signature and Seal: _____

GUIDANCE FOR FILLING CLAIM FORM - PART A (TO BE FILLED IN BY THE INSURED)

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF POLICYHOLDER		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) Name of Policy Holder	Enter the Full Name of the Patient	First Name, Middle Name, Surname
c) Address	Enter the Full Postal Address	Include Street, City, State and Pin Code
d) Date of Birth	Enter Date of Birth of Policyholder	Use DD/MM/YYYY format
e) Occupation	Indicate Occupation of Patient	Please specify the Occupation
f) Telephone Number	Enter the Phone Number of Policyholder	Include STD code with telephone number
g) Mobile No	Enter the Mobile Number of Policyholder	Please enter a 10 digit number
h) E-mail Address	Enter E-mail Address of Policyholder	Complete E-mail Address
Section 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	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) E-mail	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 of Injury/ Death	Use DD/MM/YYYY format
j) Place of Accident/ Injury/ Death	Enter the Place where the Accident/ Injury or Death Occurred	Enter Locality, City, State
k) Details and Nature of Accident	Enter details of reason and nature of Accidental Injuries	Describe the nature of Injuries and reason for Accident
l) Did the Accident happen when you were working	Indicate whether the Accident happen when you were working	Tick Yes or No
m) If Yes, Name and Address of Employer	Indicate the Full Postal Address	Include Street, City, State and Pin Code
n) Whether reported to Police	Indicate Whether you have informed and reported to Police	Tick Yes or No
o) If Yes, Name and Address of Police Station	Indicate the Full Postal Address	Include Street, City, State and Pin Code
p) If No, Give reasons	Indicate the reason for Not informing the Police	Indicate the reason for Not informing the Police
q) First Information Report (FIR) Number	Indicate the FIR number	Please give complete FIR number and Date
r) Contact Details of Police Station	Indicate the Telephone number and address of Police station	Include STD code with telephone number/ Address - Include Street, City, State and Pin Code
Section C - Details of Hospitalization immediately after the accident		
a) Name of the Hospital	Indicate the Full Name	Indicate the Full Name
b) Address of the Hospital	Indicate the Full Postal Address	Include Street, City, State and Pin Code
c) Date of Admission	Enter Date of Admission	Use DD/MM/YYYY format
d) Date of Discharge	Enter Date of Discharge	Use DD/MM/YYYY format
Section D - Details of Witnesses		
a) Was there any witness to the event	Indicate if there any witness to the event	Tick Yes or No
b) Name	Enter the Full Name of the Witness	First Name, Middle Name, Surname
c) Address	Enter the Full Postal Address	Include Street, City, State and Pin Code
d) Phone Number (Home)	Enter the Phone Number of Patient	Include STD code with telephone number
e) Phone Number (Mobile)	Enter the Mobile Number of Patient	Please enter a 10 digit number
f) Phone Number (Work)	Enter the Phone Number of Patient	Include STD code with telephone number
Section E - Details of any other personal accident policy		
a) Name of the Insurer	Indicate Full Name	Name - Enter Full Name
b) Address of Issuing office	Indicate Address of Insurer's Issuing office	Include Street, City, State and Pin Code
c) Policy Number	Enter the Policy Number	As allotted by the Insurance Company
d) Policy Period	Enter the Policy Commencement and End Date	DD/MM/YYYY to DD/MM/YYYY
e) Sum Insured	Enter the Total Sum Insured as per the Policy	In Rupees
Section F - Details of Benefits Claimed		
Please Indicate and Tick the Benefits claimed		
Section G - Check List of Enclosures for Submission of Claim		
Indicate which bills are enclosed with the Amounts in Rupees		
Section H - Details of Policyholders Bank Account		
a) Bank Name	Enter the Bank Name	Name of the Bank in full
b) Bank Branch	Enter Name of the Branch	Name of the Branch
c) Bank Account Number	Enter the Bank Account Number	As allotted by the Bank
d) IFSC Code	Enter the IFSC Code of the Bank Branch	IFSC Code of the Bank Branch in full
e) MICR Code	Enter the MICR Code	MICR Code of the Bank Branch in full
Section I - Declaration by the Insured		
Read Declaration carefully and mention date (in DD/MM/YYYY format), place (open text) and sign.		

ManipalCigna
Health Insurance

Know Your Customer

Processing your claim smoothly and quickly is of importance to you as well as us. Help us remain as your trusted service partner by ensuring we have a copy of all your documents.

ID proof (Any one of below mentioned documents required)

- 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
- Job card issued by NREGA duly signed by an officer of the State Government
- Color passport size photograph not older than 6 months

Proof of Residence (Any one of below mentioned documents required)

- Electricity bill / Ration card*
- Letter from any recognized public authority
- Current statement of bank account with details of permanent/ present residence address as stamped by bank*
- Current passbook with details of permanent/ present residence address (updated up to the previous month)*
- Valid lease agreement along with rent receipt, which is not more than three months old as a residence proof
- Telephone bill pertaining to any kind of telephone connection like, mobile, landline, wireless, etc. provided it is not older than six months from the date of insurance contract
- Employer's certificate as a proof of residence (Certificates of employers who have in place systematic procedures for recruitment along with maintenance of mandatory records of its employees are generally reliable)

*Acceptable as Address proof and Identity proof if photograph of applicant is affixed

Request you to provide declaration for crediting claim amount in your (proposer) account provided during policy issuance. **YES** ☐ **NO** ☐

We shall use below mentioned information from the policy for payment of your claim:

• Account Number • Bank Name • Payee Name • IFSC code • Branch Name

Saral Suraksha Bima, ManipalCigna | Claim Form | UIN: MCIPAIP21622V012021 | April 2021