CLAIM FORM & OTHER DOCUMENTS TO BE SUBMITTED TO LIC BRANCH/ DIVISIONAL OFFICES ONLY												
Form for claiming HCB/ MSB/ DCPB/ OSB/ Quick Cash under LIC's Health Insurance Policy (Issuance of this Claim Form does not tantamount to acceptance of Liability by the Insurer)												
LIFE INSURANCE CORPORATION OF INDI	Ā	of Hoolth Cond	Nome of	the TDA		Makila / Dhan	f D.	in ain al In a			ail ID of Driveinel Incomed	
Policy Number	UHID NO.	D NO.of Health Card Nan		lame of the TPA		Mobile / Phone of Principal Ins		ured E-mail ID of Principal Insured				
1. Quick Cash fa	cility avai	or policie	903 only)									
	Date of Major surgery Details of Major Surgery (category1 OR 2) Performing Surgeon's Name Amount of Quick Cash Availed											
Benefits now clai A. Daily Hospital C	Hosi	ospital D Major Surgica			al E. Total Benefits							
					efit Claimed Benefit C							
A . PARTICULARS (B. DETAILS OF INSURED MEMBER (In respect of whom claim is made) Name of the Insured											
Policyholder(Principal Insured)												
Communication Addr Policyholder	ess of the					Occupation of the Insured Address of the Insured						
C .PARTICULARS OF AILMENT/ DISEASE/ INJURY						Relationship of the Insured to						
Nature of						PI Date of Birth:						
disease/illness/injury						Details of pas						
Date of disease/ ii					disease with initial diagnosis							
Has the insured been						Duration of	diseas	se:				
hospitalized in the past?						In case of Road Traffic Accident , whether MLC / FIR lodged: YES /						
If yes give details NO If "YES" Please attach reports												
D. HOSPITAL AND TREATMENT PARTICULARS Name of the Hospital: Phone Number of the Hospital												
Registration No.		FAX No of the Hospital:										
						In patient No. Date of Admission: Time:						
Address of the Hospital								Discharge: Time:				
						Diagnosis:						
Covered by any other Health insurance: Give Name of the Company & Pol No: E .PARTICULARS OF ATTENDING DOCTOR												
Name of Attending Doctor & his specialisation												
Registration No: System of Medicine: Allopathy / Non-Allopathy: G. SURGICAL PROCEDURE PARTICULARS, IF ANY												
Did the hospitalization include ICU treatment YES / NO						me of surgery e of Surgery						
If "YES", Date of commencement of ICU				Nar	Name of surgeon who has performed the							
treatment / Time Date of completion of ICU						Please attach all surgical reports along with this form						
treatment/Time			Declar	ration by th								
Declaration by the policyholder / Claimant												
I hereby declare that the above information is true & correct to the best of my knowledge and belief. If I have made any false, fraudulent or untrue statement, or suppressed or concealed answers to the above questions, my right to claim under the policy shall be forfeited.												
Date: P	Place:		CI-:	. Disaba:	ac C	ortificata		Signature	e of the	policy	holder/Principal Insured	
NAME OF THE DAM	W/CODE *	10				Certificate	! ·	fo Inc	200 C=	20" 1"	on of India to marks	
NAME OF THE BAN	I hereby authorize Life Insurance Corporation of India to make payment of the above claim, admissible as per terms,											
Location						conditions and limitations of the Policy. This discharge is						
IFSC NO						delivered with full satisfaction in full and final settlement of my above mentioned claim.						
PAN NO					"	.50vc mention						
Please attach a c	Revenue											
authenticate the details given above						Stamp						
The details of Bank account and address of the Bank etc furnished by me are correct and I hereby authorize Life												
Insurance Corpora												
payment to my above mentioned Bank Account. Date: Signature of the Principal Insured						Date: Signature of the Principal Insured						
Date:	F	Place:										