Claim Intimation Form

Form to be used for Health Insurance Plans
(To be accompanied by all hospital records related to the Illness)

Note: Please complete the form in CAPITAL LETTERS

All Fields with (*) are mandatory

LIFE ASSURED DETAILS

Policy No*: Other Health Policy No:

Name of Life Assured*:

Address*:

City*: State*: PIN*

Landline*: Mobile*:

Email id*:

CLAIM DETAILS

Type of Illness:

Date of Illness: D D M M Y Y Y Y Location of Illness:

Date of Diagnosis: D D M M Y Y Y Y Name of the Hospital:

Date of Last consultation / hospitalization: D D M M Y Y Y Y Date of Discharge: D D M M Y Y Y Y

Name and Contact Number of treating Doctor:

Detailed Description (giving cause):

CLAIMANT DETAILS

This section is to be filled only if claimant is not the Life Assured and Life Assured is unable to register this claim

Name of Claimant*:

Relationship with the Life Assured: Age of Claimant*:

Address*:

City*: State*: PIN*:

Landline*: Mobile*:

Email id*:

Photo identification proof enclosed: ☐ Passport ☐ PAN Card ☐ Voter's Id ☐ Driving License ☐ Others (please specify)_____

This form is considered "PRIVATE" when completed

Continue filling the form overleaf

This form is considered "PRIVATE" when Completed

Call : 1800 419 8228 (TOLL FREE); +91 80 4134 5444 @ Email : care@exidelife.in Visit : exidelife.in

Registered Office: Exide Life Insurance Company Limited, 3rd Floor, JP Techno Park, No.3/1, Millers Road, Bengaluru - 560 001.
IRDAI Registration No. 114 CIN: U66010KA2000PLC028273

EXIDE Life Insurance

BANK ACCOUNT DETAILS

Account Number*:

Bank Name*:

Bank Branch*:

Bank Address*:

IFSC code*: 9 Digit MICR No.*:

Account Type*: ☐ Savings ☐ Current ☐ Cash Credit / Over Draft

• Please attach the personalized cancelled cheque copy of the beneficiary.*

DECLARATION

The above statements are true and correct to the best of my knowledge.

Signature / Thumb impression of Claimant:

Date*: D D M M Y Y Y Y

Name of Claimant*:

Relation to the Life Assured*:

If the executant is illiterate (affixing thumb impression) or a person subscribing his/her signature in vernacular then the witness has to attest the thumb impression / Signature and execute the following declaration:

Certified that the contents of this Form were explained by me to Mr./ Mrs./ Ms. _____ (Insert name) in _____ language and that he/she has affixed his/her signature/thumb impression thereto in my presence after thoroughly understanding the same. I have truthfully recorded the replies.

Signature of Witness: Name of the Witness:

Address:

City*: State*: PIN*:

Mobile*:

This form is considered "PRIVATE" when completed

ATTACHMENTS

ATTACHMENTS TO THIS FORM

(a) Original Policy Document ☐

(b) Address proof & Identification document (with Photo) of Life Assured ☐

(c) Proof of Bank account of claimant (personalized cancelled cheque / Bank Passbook with Photograph and Account statement of last '6' months) ☐

(d) Medical Reports and Records
- For initial Diagnosis ☐
- Test / Investigation reports including all clinical treatments like, radiological, histological and laboratory test evidence (e.g. 2D echocardiogram, treadmill test, USG etc.) as applicable. ☐

(e) Histopathology Report in case of Cancer claims ☐

Note: Depending on the nature of a claim, case specific additional relevant information may be required.

HCIF/VER1.0/SEP2017

ACKNOWLEDGMENT SLIP

This is to acknowledge the receipt of intimation for Health claim

Policy No: Date: D D M M Y Y Y Y

Documents Received: ☐ Policy Document: ☐ Attachments specified

Bank account details of the Life Assured/ Claimant: _____

Customer Service Executive Signature

Date: D D M M Y Y Y Y

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