

**CLAIM FORM  
SBI LIFE – HOSPITAL CASH**

**INSURED DETAILS**

Name of Insured for whom the claim is lodged: \_\_\_\_\_  
 Policy Number: \_\_\_\_\_ Customer ID Number: \_\_\_\_\_  
 Address of the Insured: \_\_\_\_\_  
 \_\_\_\_\_  
 City: \_\_\_\_\_ State \_\_\_\_\_  
 E-mail ID \_\_\_\_\_ Tel No: \_\_\_\_\_  
 Date of Birth: dd/mm/yyyy  
 Is the insured covered under any hospital cash policy with SBI Life: Yes  No   
 If Yes then, Policy Number: \_\_\_\_\_

**CLAIM DETAILS**

Diagnosis of illness/ disease :	
Date of diagnosis dd/mm/yyyy	Date of first consultation dd/mm/yyyy
Date of Admission dd/mm/yyyy	Date of discharge dd/mm/yyyy
No of days in Ward _____	No of days in ICU _____

**CASES DUE TO ACCIDENT**

Is the hospitalization due to accident? Yes <input type="checkbox"/> No <input type="checkbox"/>
Date of Accident dd/mm/yyyy :                      FIR No.
Police Station name and address:

Brief narration of how the accident happened (if accidental hospitalization):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HOSPITAL AND TREATING DOCTOR'S DETAILS**

Name of the Hospital: \_\_\_\_\_  
 Address of the Hospital: \_\_\_\_\_  
 \_\_\_\_\_  
 City: \_\_\_\_\_ State \_\_\_\_\_  
 Tel No: \_\_\_\_\_  
 No of In-patient beds: \_\_\_\_\_  
 Name of the treating doctor under whom the admission was taken: \_\_\_\_\_  
 \_\_\_\_\_  
 Qualification of the doctor: \_\_\_\_\_

Name of the Treating Doctor(s)	Contact Number	Date of First consultation	Treatment Taken

Is the insured suffering from any pre-existing disease or was the treatment taken in hospital related to any pre-existing disease? Yes                      No

If Yes Provide details of disease including the name and time since suffering: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PLEASE TICK ON THE FOLLOWING DOCUMENTS ATTACHED WITH CLAIM FORM**

Copy of policy document <input type="checkbox"/>	Valid age proof* <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hospital Discharge card	Treating doctor's certificate confirming admission and diagnosis
Copy of medical Records	Hospital bill Payment receipts

**CLAIMING FOR FAMILY CARE BENEFIT**

Yes

No

IF YES: Name of the other insured who has been hospitalized for the same ailment continuously for a period of 5 or more consecutive days: \_\_\_\_\_

**BANK DETAILS OF THE INSURED/ CLAIMANT**

Name of Bank	
Branch Code Number	
IFCS Code Number	
Account Number	
Address of the Bank	

**DECLARATION**

I /We, the above-named Insured/ claimant(s), do solemnly declare that the foregoing answers and statements are true in all respects, and further agree that the furnishing of this form, or any other form supplemental thereto, to the Company, shall not constitute an admission by the Company that there was any insurance in force on the life in question or a waiver of any rights or defense. Notwithstanding, any law, custom or usage, prohibiting the furnishing of secret information obtained during the medical treatment / investigation of Life Insured,

I/We hereby authorize any doctor or other person, or any hospital, sanatorium, medical professional, hospital or other medical care institution, insurance support organization, pharmacy, governmental agency, insurance company, employer, benefit plan administrator, accountant, or financial adviser or other institute to provide to SBI LIFE INSURANCE COMPANY LTD, any of its offices, or Court of Law, or any investigative agency or independent administrator acting on its behalf, information concerning employment, finances or insurance, advice, care or treatment provided to Insured, or any information that may be required concerning the health of the Insured including information relating to mental illness, use of drugs, use of alcohol, HIV(AIDS Virus) and /or sexually transmitted diseases. A Photostat copy of this authorization shall be considered as effective and valid as the original.

**Signature / Thumb Impression of Life Insured**

\_\_\_\_\_  
Place \_\_\_\_\_  
Date \_\_\_\_\_

**In case the Life assured is unable to sign/ is a minor: Signature of Primary life assured/ Proposer/ Nominee**

Name: \_\_\_\_\_  
Place \_\_\_\_\_  
Date \_\_\_\_\_

**PLEASE PROVIDE THE FOLLOWING DETAILS OF THE CLAIMANT**

Name of Claimant: \_\_\_\_\_

Status: Primary Life Assured  Proposer  Nominee

Date of Birth: dd/mm/yyyy

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Tel No: \_\_\_\_\_ Place: \_\_\_\_\_

**The claim form along with the aforementioned documents should be sent to the following address**

**E-Meditek (TPA) Services Limited- Claims department**

208/209 Turf Estate,

Off Dr.E.Moses Marg,

Beside Mahalakshmi Satation, Mahalakshmi

Mumbai, Toll free number - 1800 102 3242

**AGE PROOF\***

**Standard  
Age  
proof**

- a) Birth Certificate issued by the Municipal authorities
- b) School / College Certificate, Board / University admit card / marks sheet, Transfer certificate issued by the school / college in a authorized format duly signed and sealed; It is mandatory that School / College certificates bear name and address of School / College and registration / admission number and date of registration / admission along with name and father's name of the life to be assured
- c) Passport
- d) Service Extract in case of Central Govt. / State Govt. / Municipal / PSU / Reputed organizations and companies
- e) Baptism Certificate / Marriage Certificate in case of Roman Catholics
- f) Defense ID card
- g) Domicile Certificate
- h) Gram Panchayat Certificate :should be an extract from the register of Gram Panchayat with the serial number of the record on the register appearing thereon
- i) Valid Driving License
- j) PAN Card
- k) Provident Fund Statement issued by the Employer in case of PSU employees
- l) Pension Order of self
- m) Employee Identity Card (bearing DOB) issued by Central Govt. / State Govt. / Municipal authorities / PSU / Reputed private Company for their employees