(Standard Claim Form As prescribed by IRDA for Health Products)

Liberty Group Personal Accident Policy
Claim Form-Part A

TO BE FILLED IN BY THE INSURED PERSON
(The issue of this Form is not to be taken a s an admission of liability)

SECTION A- DETAILS OF PRIMARY INSURED

a)Policy Number: b) SL No / Certificate No/ Claim Number (If any):

c)Company/ TPA ID no

d)Name

h)Address

i) City j) State k) Pin Code

l) Phone No: m) Email ID:

SECTION B. DETAILS OF INSURANCE HISTORY

a) Currently Covered by any other Mediclaim / Health Insurance? YES / NO

b) Date of commencement of first Insurance without break: dd mm yy

c) If YES, -
Company Name: Policy Number:

Sum Insured:

d) Have you been hospitalized in the last four years since the inception of the contract? YES / NO
DATE : MM YY

Diagnosis:

e) Previously covered by any other Mediclaim / Health Insurance: YES/ NO

f) If Yes company name:

SECTION C. DETAILS OF INSURED PERSON HOSPITALIZED

a) Name:

b) Gender: Male / Female c) Age: …. Years …. Months d) Date of Birth : DD MM YY

e) Relationship of Primary Insured: Self/ Spouse/ Child/ Father/ Mother/ Other (Please Specify… .....)

f) Occupation: Service/ Self Employed/ Homemaker/ Student/ Retired/ Other (Please specify….....)

g) Address (If different from above) :

City State Pin Code

Phone No: Email ID:

SECTION D. DETAILS OF HOSPITALIZATION

a) Name of the Hospital where admitted

b) Room Category Occupied: Day care / / Single occupancy / Twin sharing / 3 or more

c) Hospitalization due to : Illness / Injury / Maternity

d) Date of Injury / Disease first detected / Date of Delivery: DD MM YYYY

e) Date of Admission: DD MM YY Time : HH MM f) Date of Discharge: DD MM YY Time : HH MM

h) If injury, give cause : Self Inflicted / Road Traffic Accident/ Substance Abuse or Alcohol Consumption

i) If Medico legal : YES/ NO j) Reported to Police: YES/ NO k) MLC report or Police FIR attached: YES / NO

l) System of medicine _____

SECTION E. DETAILS OF CLAIM

a Details of Treatment Expenses Claimed

1. Pre Hospitalization Expenses: Rs ……. 2. Hospitalization Expenses: Rs ..... 3. Post Hospitalization Expenses: Rs……..
4. Health Check Up cost: Rs……. 5. Ambulance Charges: Rs …… 6. Others (Code) Rs ..…
Total: **Rs…….....**

- Pre Hospitalization Period : _days
- Post Hospitalization Period : _days

b Claim for Domiciliary Hospitalization : YES / NO
(If Yes provide details on annexure)

c Detail of Lump Sum cash benefit claimed

Liberty General Insurance

☐ **Hospital Daily Cash: Rs ……..** ☐ **Surgical cash: Rs ……..** ☐ **Critical Illness: Rs ……..**

☐ **Convalescence: Rs ……..** ☐ **Pre Post Lump Sum: Rs ……**

☐ **Other Rs ……..** ☐ **Total : Rs……**

Claim Documents Submitted Check List

- ☐ **Claim Form Duly Filled**
- ☐ **Copy of the Claim Intimation, if any**
- ☐ **Hospital Main Bill**
- ☐ **Hospital Break Up Bill**
- ☐ **Hospital Bill Payment Receipt**
- ☐ **Hospital Discharge Summary**
- ☐ **Pharmacy Bill**
- ☐ **Operation Theater Notes**
- ☐ **ECG**
- ☐ **Doctor's request for investigation**
- ☐ **Investigation Reports (Including CT/MRI/USG/HPE)**
- ☐ **Doctor's Prescription**
- ☐ **Others**

F.DETAILS OF BILLS ENCLOSED

Sl. No	Bill No	Date	Issued by	Towards	Amount
				Hospital Main Bill	
				Pre Hospitalization Bills	
				Post Hospitalization	
				Pharmacy Bills	
				Total	

Please attach separate sheet for additional bills / receipt details

G. DETAILS OF PRIMARY INSUREDS BANK ACCOUNT

a) PAN No: b) Account Number

c) Bank Name/ Branch:

d) Payable details: Cheque/ DD/NEFT* Payable to:

e) IFSC Code:

H. 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 TPA / 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. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

I/We hereby give voluntary consent to Liberty General Insurance Limited/Company to process/share my/our personal information and data provided in this form with its group companies or any other person/ Service Provider of Company in connection with the Insurance Policy/ claims made there under or otherwise, including for providing other products of the Company that may be of interest to me/us, to be used in accordance with their respective privacy policies

Date: PLACE Signature of the Primary Insured Person / Claimant

GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) SI. No/ Certificate No.	Enter the social insurance number or the certificate number of	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin Code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health	Indicate whether currently covered by another Mediclaim /	Tick Yes or No
b) Date of Commencement of first Insurance	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name	Enter the full name of the insurance company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last 4	Indicate whether hospitalized in the last 4 years	Tick Yes or No
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Mediclaim/ Health	Indicate whether previously covered by another Mediclaim /	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option

d) Date of Injury/Date Disease first detected/ Date of	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) If Injury give cause	Indicate cause of injury	Tick the right option
If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicine	Enter the system of medicine followed in treating the	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
d) Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amounts in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be	Name of the individual/ organization in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

Liberty General Insurance

CLAIM FORM – PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of this Form is not to be taken as an admission of liability

Please include the original preauthorization request form in lieu of PART A (To be filled in Block Letters)

SECTION A. Hospital Details:					
Name of the Hospital			Hospital ID		
Type of Hospital	Network		Non Network		
If Non Network fill sec E					
Name of the treating Doctor					
Qualification	Registration No with State Code:		Phone No:		

SECTION B. Details of the patient admitted:				
Name of the patient		IP Registration Number		
Gender	Male/ Female	Age	Date of Birth: DD MM YYYY	
Date of Admission		Time of Admission		
Date of Discharge		Time of Discharge		
Type of Admission	Emergency	Planned	Day-care	Maternity
If Maternity Date of delivery		Gravida Status		
Status at the time of Discharge: Discharge to Home/ Discharge to another Hospital/ Deceased Total Claimed Amount: …….				

SECTION C. DETAILS OF AILMENT DIAGNOSED						
Ailment Diagnosed (Primary)						
ICD 10 Code	Primary Diagnosis	Codes Description	Additional Diagnosis	Codes Description	Co-morbidities	Codes Description
Details of Procedure/s done						
ICD 10 PCS	Procedure 1	Code & Description	Procedure 2	Code & Description	Procedure 3	Code & Description

Pre authorization Obtained	YES/ NO	PRE AUTHRIZATION NUMBER	…….
Hospitalization due to Injury	Yes/ No	If Yes Give cause	Self-Inflicted/ Road Traffic Accident / Substance Abuse / Alcohol Consumption
Reported to police	YES / NO	Medico Legal	YES / NO
FIR No	If not reported to police , give reasons		
If injury due to Substance Abuse/ Alcohol consumption test conducted to establish this? If YES please attach Report			YES/ NO
If authorization by network hospital not obtained, give reason			
Note: For details of Claim Documents to be submitted, please refer checklist			

Claim Document Submitted - Checklist

❑ Claim Form Duly signed

- ❑ Original Pre-Authorisation Request
- ❑ Copy of Pre-Authorisation Approval Letter
- ❑ Copy of Photo Id Card of Patient verified by the Hospital
- ❑ Hospital Discharge Summary
- ❑ Operation Theater Notes
- ❑ Hospital Main Bills
- ❑ Hospital Break-up Bill
- ❑ Investigation reports
- ❑ CT/MRI/USG/HPE investigation reports
- ❑ Doctor's reference slip for investigation
- ❑ ECG
- ❑ Pharmacy Bills
- ❑ MLC report & Policy FIR
- ❑ Original Death Summary from Hospital where applicable
- ❑ Any other, please specify.

Details in case of Non network Hospital (only fill in case of non –network hospital)
Address of the Hospital

Address of the Hospital	
City	
State	
Pin Code	
Phone No	
Registration no with state code	
Hospital PAN	
No of Inpatient Beds	
Facilities in the Hospital	OT □ Yes □ No ICU □ Yes □ No
Others	

DECLARATION BY THE HOSPITAL

We hereby declare that the information furnished in this Claim Form is true and correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppressed or concealed any material fact, our right to claim under this Policy shall be forfeited.

SEAL & SIGNATURE OF THE HOSPITAL AUTHORITY **Date**
Place

Liberty Group Personal Accident Policy
Claim Form

Basic Information

Policy No: Claim No:
Insured Name:
Insured Person Name:
Claimant Name:
Relationship:
Address:

City Pin ode

Contact No: Residence Office: Mobile:

Occupation DOB

Accident Details

Date of Accident
Time of Accident
Place & Location:
Description of accident/Incidence:

Details of injuries sustained

Specify injured parts of the body:

Please specify nature of Disability:

Please mention Disability percentage in case of Permanent partial disablement, certified by Doctor: %

Witnesses

Name:
Address:

Contact No: Residence Office: Mobile:

Liberty General Insurance

Tick Against the Section Claimed for:

Basic Cover:	Death	PTD	PPD	TTD

Extension Covers:	Child Education Support	Performance of Funeral Ceremony
	Transportation of Mortal Remains	Modification of Vehicle / Residence
	Accidental Medical Expenses	Family Transportation Benefit
	Accidental Hospital Daily Cash	Outstanding Bills Protection Benefit
	Life Support Benefit	Ambulance Hiring Charges
	Loan Protector	Legal Bail Expenses
	Broken Bone	Double Indemnity
	Evacuation Expenses	

Treatment Details

Casualty Doctor	Name: Address: Tel Nos:
Family Doctor	Name: Address: Tel Nos:
Hospital Details	Name: Address: Tel Nos:

Confinement

Inpatient treatment From *dd/mm/yyyy* To *dd/mm/yyyy*

Outpatient treatment From *dd/mm/yyyy* To *dd/mm/yyyy*

Total Confinement: From *dd/mm/yyyy* To: *dd/mm/yyyy*

(This should be the actual days when fully confined to bed on Medical Advice)

Details of medical expenses:

Date:	Receipt No	Particulars	Amount
Please attach separate sheet for additional bills / receipt details			

Policy and Claims History:

A) Have you made any Claims in Past? Yes
No
B) If YES, Please give details including nature of Accident, Insurance details & Claim amount

C) Are you insured under any other Policy? Yes
No
If YES, Please give full particulars

Name of Company	Policy No	Policy Period	Policy Issuing Office

Declaration

I/We agree to provide additional information to the company, if required. I/We the above mentioned, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and if I/We have made, or in any further declaration the company may require in respect of the said accident, shall make any false or fraudulent statement,or any suppression or concealment, the policy shall be void and all rights to recover there under in respect of past or future accident shall be forfeited. I hereby consent to Liberty General Insurance Limited approaching my doctor for all information that it deems to be necessary

I/We hereby give voluntary consent to Liberty General Insurance Limited/Company to process/share my/our personal information and data provided in this form with its group companies or any other person/ Service Provider of Company in connection with the Insurance Policy/ claims made there under or otherwise, including for providing other products of the Company that may be of interest to me/us, to be used in accordance with their respective privacy policies.

Place

Date

Sign/ Thumb Impression of the Insured/ Insured Person

Liberty General Insurance

Attending Physician Statement *(To be filled by the Treating Doctor)*	
Name & Age of the Insured Person	
Address	
Nature of the Accident	
Details of the Injuries sustained	
Does the Cause of Accident as stated by the Claimant tally with the Injuries noticed by you?	Yes No
Are the injuries solely due to the accident If No, Please provide the details:	Yes No
Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition	Yes No
Was the claimant hospitalized? If so for what period?	From To
What treatment was given and operations performed?	
Give all dates of treatment:	Clinic/Hospital: From To Home: From To
Was he/she under the influence of intoxicants or drugs at the time of accident?	Yes No
Are you his family doctor?	Yes No
Please give the details, If you have treated him for any previous illness or injury?	
Have other Doctors been in Attendance or Consultation? If Yes, Please give the details	Yes No
Has this accident been reported to the Police Authorities? If Yes, then please provide	Yes No Case No: Police Station:
Is this claimant Totally Disabled from each and every occupation?	Yes No
How long was or will the claimant be totally disabled from current occupation?	From To
How long was or will the claimant be partially disabled from current occupation?	From To
Estimated date of return to Work	Date: dd/mm/yyyy
What is the Prognosis?	
Doctor's Name	
Qualification	
Address	
Tel No	
Registration No	
Signature	

Date: ……. Signature and Seal of the Doctor / Hospital

Check List of Indicative Documents to be submitted for Group Personal Accident Claims

In case of Personal Accident Death claims

a) FIR from police authorities wherever necessary (in case of accidents outside residence)
b) Death Certificate from the Municipal Authorities
c) Death Summary from the Hospital Authorities if death is confirmed by the Hospital
d) Post Mortem Report, if conducted
e) Documentary proof of accidental death
f) Duly filled and signed claim form
g) Legal Heir Certificate & Succession Certificate
h) Policy Copy and Annexure
i) Inquest / Panchnama Report
j) Photographs of the insured
k) Coroner's Report
l) Letter from HR stating the attendance closure to the incident

In case of Personal Accident Permanent Partial and Total Disability claims

a) FIR from police authorities wherever necessary (in case of accidents outside residence)
b) Medical Certificate from the attending Medical Practitioner for the injury indicating the extent of disability
c) Duly filled and signed claim form
d) Policy Copy and Annexure
e) Hospital / Nursing Home Medical Records
f) Leave certificate from HR (for salaried people)
g) Salary certificate / income proof
h) Photographs of the insured showing affected area

In case of Personal Accident Temporary Total Disability claims

a) FIR from police authorities wherever necessary (in case of accidents outside residence)
b) Medical Certificate from the attending Medical Practitioner for the injury indicating the extent of disability
c) Medical fitness certificate from the Treating consultant indicating duration of rest medically advised
d) Duly filled and signed claim form
e) Policy Copy and Annexure
f) Hospital / Nursing Home Medical Records
g) Leave certificate from HR (for salaried people)
h) Salary certificate / income proof
i) Photographs of the insured showing affected area

In case of claim under other covers:

Child Education Support:

- Proof of number of dependent child /children viz. Ration card
- Age proof of the dependent child /children
- Proof of education and payment of fee

Transportation of Mortal remains:

- Bills and receipt towards cost of transportation of the mortal remains to the place of residence/hospital and/or cremation/burial ground.

Performance of Funeral Ceremony:

- Bills and receipt towards expenses relevant to funeral ceremony.

Accidental Medical Expenses

- Copy of document of hospitalization/medical treatment
- Certificate from treating doctor about the diagnosis and line of treatment given during hospitalization/medical treatment
- Bills and receipts towards medical expenses.
- Copy of the test reports
- Hospital / Nursing Home Medical Records, when required for verification of claims

Accidental Hospitalisation Expenses (In-patient)

- Copy of document of hospitalization/medical treatment
- Certificate from treating doctor about the diagnosis and line of treatment given during hospitalization/medical treatment
- Bills and receipts towards medical expenses.
- Copy of the test reports
- Hospital / Nursing Home Medical Records, when required for verification of claims

Accidental Hospitalisation Expenses (Outpatient)

- Copy of document of medical treatment
- Certificate from treating doctor about the diagnosis and line of treatment given during medical treatment.
- Clinic/ Diagnostic Centre/Hospital / Nursing Home Medical Records, when required for verification of claims
- Bills and receipts towards medical expenses.
- Copy of the test reports

Accidental Hospital Daily Cash

- Copy of document of hospitalization
- Certificate from treating doctor about the diagnosis and line of treatment given during hospitalization

Life Support

- Permanent Total Disability related documents

Loan Protector

- Accident Death /Permanent Total Disability related documents
- Loan documents from financial institution/s

Broken Bone

- Bills and receipts towards medical expenses

- Copy of the test reports
- X Ray plates reflecting broken bones

Modification of Vehicle / Residence
- Permanent Total Disability / Permanent Partial Disability related documents
- Bills and receipts towards vehicle or residence modifications

Family Transportation Benefit
- Accidental Death / Permanent Total Disability / Permanent Partial Disability related documents
- Bills and receipts towards travel expenses of family member/s

Outstanding Bills Protection Benefit
- Proof of outstanding Bills

Ambulance Hiring Benefit
- Bills and receipt towards cost of ambulance services

Cost of Support Devices:
- Doctor's prescription advising the use of such devices
- Permanent Total Disability / Permanent Partial Disability related documents
- Bill and receipts towards Support devices and their installation

Marriage Expenses for Children:
- Proof of number of dependent child /children viz. Ration card
- Age proof of the dependent child /children
- Accidental Death / Permanent Partial Disability related documents

Loss/Damage to School Accessories
- Bill and receipts towards the same

Loss of Job cover
- FIR from police authorities wherever necessary (in case of accidents outside residence)
- Medical Certificate from the attending Medical Practitioner for the injury indicating the extent of disability
- Duly filled and signed claim form
- Policy Copy and Annexure
- Hospital / Nursing Home Medical Records
- Leave certificate from HR
- Salary certificate / income proof
- Photographs of the insured showing affected area
- Relieving /termination/resignation letter

Legal Bail Expenses
- Notice & Receipts of the bail expenses incurred.

Double Indemnity
- Proof of travel through Public Carrier and subsequent accident**.**

Evacuation Expenses

- Certificate from licensed physician about the diagnosis
- Bills and receipts towards evacuation expenses.

We may ask for additional requirement in certain peculiar cases as per the nature of claim.