Liberty General Insurance

OVERSEAS TRAVEL INSURANCE CLAIM FORM

1. Please answer all the questions completely, in case of space constraint attach an additional sheet.
2. Please sign the claim form and attach all Original bills and receipts towards your claim.
3. Please attach Original ticket/boarding pass along with the copy of passport with entry and exit stamp with the claim form.

Policy No. /Certificate No.:-
Policy Start Date: DD/MM/YYYY Policy End Date: DD/MM/YYYY

Claim reference number (if claim was notified):----------

Reasons for not notifying the claim (if claim was not notified):----------

Name of Insured: ----------
*E-Mail ID: ----------
Contact No. in India: Mobile ---------- Landline:----------
Contact details Abroad:----------

Passport No: ----------
Date of Departure: DD/MM/YYYY Date of Arrival: DD/MM/YYYY

*Please Fill the Section Relevant to Your Claim Completely

Medical Expenses:

Name, Address and contact details of the Hospital/Institute/Clinic where the treatment was given:--

Name of Treating Doctor (with Registration No. & Qualification):----------

Details of the Illness, Accidents presenting complaints, diagnosis and treatment provided:----------

---

Date of First Consultation: ---

Please mention the past medical history with duration of any illness, accident or hospitalization with details:---

Any past Medical History of:

Ailment	Yes/No-Duration if Yes	Ailment	Yes/No-Duration if Yes
Hypertension		Cancer	
Asthma		Arthritis	
Diabetes Mellitus/Insipidus		Cardiac Ailments	

Current illness is related to any pre-existing condition: Yes/No

Were you treated for this illness before:---

If Yes, provide the details of consulting doctor with address and phone no.:---

Provide Name, address and phone no. of your regular physician in India: ---

Current illness is related to Pregnancy: Yes/No

Is the Insured totally disabled?-Yes/No

Please specify the duration of total disablement: ---

Please specify the duration of partial disablement: ---

For Accidental Injury:---

Date and Circumstances of injury:---

X-Ray/CT scan/MRI done: Yes/No Date: DD/MM/YYYY

Diagnosis and treatment Details:---

Are all injuries out of current accident or traceable to past accident/injury/disease:----------
---
Was the Insured under the influence of alcohol/intoxicating drugs at the time of accident: ----------
Prognosis: ----------
Is Medical Evacuation to India recommended/required: Yes/No
Please provide the reason for Medical Evacuation: ----------

Signature of Treating Doctor:----------Date----------Reg. No----------
Doctor's Name with Detailed address and phone no, e-mail ID ----------
---

Stamp/Seal:
……
……
Have You received medical services from more than one physician? Yes/No
Names of the treating physicians with contact details and e-mail ID:

1) ----------

---
2) ----------

---
3) ----------

---
4) ----------

---
5) ----------

Have you attached all the bills towards medical services opted for? Yes/ No
Kindly provide the details towards the additional bills which are yet to be submitted for assessment,

S.no	Type/Name of Service(s)	Prescribed By(Dr.Name)	Invoice Number	Invoice Amount
1				
2				
3				
4				
5				
	Total Amount			

*I hereby declare that there are no additional bills other than mentioned above towards any medical services opted during the trip.

Repatriation of Mortal Remains:

Cause of Death: ----------
Date of Death: DD/MM/YYYY

Dental treatment:

Name, address and contact details of the Hospital/clinic where treatment was given: ----------
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Name of Dental Surgeon with Reg.No: ----------
Details of Ailment:----------

First Consultation Date: DD/MM/YYYY
Current Illness is related to any pre-existing condition: Yes/No
Nature of Treatment given:----------

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*Please attach the medical reports, consultation papers, all investigation reports, prescriptions, pharmacy bills, receipts in original, Government Certificate towards Temporary/permanent disablement, FIR and death certificate and post mortem report in case of death.

Hospital Confinement:

Date and time of admission: DD/MM/YYYY-00:00 Date of Discharge: DD/MM/YYYY-00:00

Delay/Loss of Baggage:

Details of time, location and circumstances of delay/loss of Baggage: ----------
---

Name of the Common Carrier with port of Arrival: ----------

Scheduled date and time of Arrival of Common Carrier: DD/MM/YYYY – 00:00hrs
Actual date and time of Arrival of Common Carrier: DD/MM/YYYY – 00:00hrs
Date and Time of Baggage retrieval: DD/MM/YYYY – 00:00hrs
Compensation paid by Common Carrier: INR ----------
*Please attach the property irregularity report, proof of ownership of items above 100$, compensation certificate from Common Carrier and original bills towards the emergency items purchased.

Item	Date of Purchase	Place of Purchase	Amount

Total Amount			
Compensation Paid by Common Carrier			
Net Amount (Total Amount- Compensation Paid by Common Carrier)			

Loss of Passport/Credit/Debit Card/International driving License:

Place and date of Loss: ---------- DD/MM/YYYY – 00:00

Expenses incurred in Obtaining New Passport/ Credit/Debit Card/International Driving license:

S.No	Services	Date	Place	Amount

*Please attach FIR lodged with Local Police authority within 24 hours of loss of passport/credit/debit card/international driving license and original bills ofamount spend for obtaining a fresh/duplicate Passport.

Hijack Distress Allowance:

Name of Common Carrier: ----------

Date and Time of Hijack: DD/MM/YYYY – 00:00hrs Date and Time of Release: DD/MM/YYYY – 00:00hrs

*Please attach police report confirming the hijack of the Carrier and mentioning the passport no. and hijack period.

Trip Cancellation/Delay/Curtailment:

Reason for Trip Cancellation/Delay/Curtailment: ----------

Date and Time of Incident: DD/MM/YYYY – 00:00hrs

*Please attach the medical reports and doctor's certificate in case of medical reasons for trip cancellation/delay/curtailment.

Missed connection:

Name of Common Carrier: ----------

Scheduled date and time of Arrival of Common Carrier: DD/MM/YYYY – 00:00hrs

Actual date and time of Arrival of Common Carrier: DD/MM/YYYY – 00:00hrs

Date & Time of Departure of Connecting flight: DD/MM/YYYY – 00:00hrs

Reason for Delay:----------
---

*Please attach confirmation from airlines.

Bounced Hotel/ Airline Bookings:

Name of Booked Hotel/Airlines: ----------
Booking date: DD/MM/YYYY Confirmation Date: DD/MM/YYYY
Reason for Bounced Booking:----------

S.No	Services	Date	Place	Amount

*Please attach the confirmation from airlines/booked hotel mentioning confirmation of bookings and the same being bounced due to overbooking, tariff card, original bills towards bookings indicating cost of stay/travel and cancellation charges applied and original bills towards alternative accommodation/travel.

Personal liability:

Name of Aggrieved Third Party: ----------
Place and date of loss: ----------Date: DD/MM/YYYY
Reason for Loss(Details):----------

---

*Please attach proof of judicial decision given by court of law.

Child Escort Cover:

Name(s) of the Child (ren) With Date of birth: 1) ----------, 2) ----------
---
Name of Common Carrier insured child is Boarding: ----------
Date and Time of Departure: DD/MM/YYYY – 00:00hrs
Reason for Unaccompanied travel: ----------

Date of Loss: DD/MM/YYYY
Nature of Ailment:----------
*Please attach the boarding pass/ticket, medical reports, disablement certificate, certificate from treating doctor confirming the disablement for travel for 7 days, death certificate (if applicable) and passport copy with entry and exit stamp.

Emergency Catastrophe Cover:

Name of Booked Hotel: ----------
Booking date: DD/MM/YYYY Confirmation Date: DD/MM/YYYY
Name & address of Emergency accommodation:----------

Reason for Leaving the Hotel:----------

S.No	Services	Date	Place	Amount

*Please attach the confirmation from Booked Hotel mentioning confirmation of bookings and the same being left due to catastrophe, FIR copy, New Paper cutting if available, tariff card, and original bills towards emergency accommodation indicating cost of stay.

Volcanic Eruption Cover:

Details of Booked Flight: ----------
Travel date: DD/MM/YYYY – 00:00hrs
Name & address of Emergency accommodation:----------

Date & Time of check in: DD/MM/YYYY – 00:00hrs
Date & Time of check out: DD/MM/YYYY – 00:00hrs

S.No	Services	Date	Place	Amount

*Please attach the confirmation from Airlines mentioning the reason for flight cancellation, New Paper cutting if available, tariff card, and original bills towards emergency accommodation indicating cost of stay.

Accidental Injury to Pet:

Name, Address and contact details of the Clinic where the treatment was given:----------
---

Name of Treating Doctor (with Registration No. & Qualification):----------
---
Details of the Illness, presenting complaints, diagnosis and treatment provided:----------
---

Date of First Consultation:----------
*Please attach the legal document towards ownership of the pet, all prescriptions and bills towards the incurred medical expenses.

Home Burglary:

Date & circumstances of incident: ----------

Any other insurance covering the loss: Yes/No. Please provide details, if Yes: ----------
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*Please provide the FIR copy, surveyor report, investigation report carried out by local authorities, requested additional documents if required.

Emergency cash Arrangement:

Date and Circumstances of Loss:----------

Value of the items lost:----------

I hereby declare that the above reason was the only reason for my loss of travel funds. I also declare that there are no other sources of funds available to me and the financial assistance required by me are needed on an urgent basis to prosecute the remainder of my trip. I have made all efforts to recover my money unsuccessfully, and if I do secure my money at a future date, I shall repay to the Company the total claim amount given to me.

---------- ----------

SIGNED (Claimant or authorized person) Relationship with the Insured

*Please attach Police report in original filed within 24 hrs of becoming aware of loss.

Declaration

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 fortified. I also consent and authorize TPA/Insurance Company, to seek necessary medical information / documents from any hospital /Medical Practitioner who has attended on the person against whom the claim is made. I hereby declare that I have included all the bills /receipts for the purpose of this claim and that I will not be making any supplementary claim except the pre/ post hospitalization claim, if any.

I do hereby authorize The Company/ Claims administrator/International Police or legal authority to inquire and obtain any information regarding my accident. Further, Liberty General insurance Company is hereby authorized to release any and all information, including copies of pertinent documents, which International Police or legal authority may deem necessary in order to satisfy their inquiry.

Place : _____

Date: _____Signature of the claimant

*Please read the policy wordings for detailed requirements of documents.

Insurance is the subject matter of the solicitation

All information received as a result of this release will not be disseminated to any other entity without the expressed written authorization of the Plan participant, or the Member, if the Participant is a minor. This authorization is valid for one year from the date of signature.

Mandate Form for Electronic Transfer of Claim/Refund/Commission/Other Payments

To **Liberty General Insurance Company Ltd**	Office Name : Office Address :

Name of Account Holder in Capital Letters: Shri / Smt / Kum / M/s
□□□
□□□□□□□□

(As appears in your bank account)

Contact / Mobile No: □□□□□□□□□□Email ID:
□□□□□□□□□□□□□□□□□□□□□□
Permanent Account No. (PAN) □□□□□□□□□□□□□□
Service Tax No.□□□□□□□□□□□□□□

Particulars of bank:

Bank Name:	

Branch Name & Address with Contact No:	

Branch MICR Code	X	X									

Branch IFSC Code for NEFT											
Branch IFSC Code for RTGS											

Account Type		Savings		Current		Cash Credit

Account No. ***(as appearing in the cheque book)***															

(<u>Please attach copy of a cancelled blank cheque of your bank for ensuring accuracy of the bank name, branch name and account number</u>)

I/we have read the declarations / conditions mentioned overleaf.

Place: _____________ ___________________________(Beneficiary's Signature)
Date: _______________

DECLARATION

- I / We hereby declare that the particulars given above are correct and complete.
- I / We further agree to refund, at any time, any excess amount whether demanded by Liberty General Insurance Company Limited or not, which has been credited to my account [due to any reason] by Liberty General Insurance Company Limited, in excess of (i) the amount due to me, or (ii) in excess of amount for which I gave mandate, and or (iii) agreed rent/license fees/compensation/refundable security deposit/Commission/Claim/Refund/ Any other payment.
- I / We agree that the payment will be endeavored to be credited starting from the date of next payment cycle and unless the Mandate is revoked by me/us issuance of relevant credit instruction for electronic payment from Liberty General Insurance Company Limited into the aforesaid account will be valid discharge to Liberty General Insurance Company Limited for having paid (i) the amount due to me, or (ii) in excess of amount for which I gave mandate, and or (iii) agreed rent/license fees/compensation/refundable security deposit/ Commission/Claim/Refund/ Any other payment.
- I / We further confirm that I/we understand this mode as a method of payment introduced by Reserve Bank of India, which provides us an option to receive the amount and or to collect our payments by electronic payment mode directly through my/our bank accounts.
- I / We further confirm that Liberty General Insurance Company Limited will have, at its sole discretion, the right to return back to the option of paying to me/us by way of cheque if there are more than 2 consecutive failures in remittances for no fault on the side of Liberty General Insurance Company Limited.
- After Liberty General Insurance Company Limited issuing the Payment instruction electronically through its banker, for whatever reasons, if I/we do not get the credit to my/our account, then same shall neither constitute the default in (i) Payment of amount requested by me, or (ii) Payment of amount due to me/us, or (iii) Payment of agreed rent/license fees/compensation/refundable security deposit/ commission/claim/ Refund/Any other payment by Liberty General Insurance Company Limited nor constitute default of any terms and conditions of any agreement/MOU/ Claim/Refund/Other contract and or Lease agreement/Leave and license agreement with me/us.

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

Liberty Overseas Travel 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

☐ **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 Bills	
				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.

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.

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

CONSENT FOR DISCLOSURE OF MEDICAL INFORMATION FORM

Patient Name: _____

Date of Birth: DD/MM/YYYY

Passport No: _____

Inpatient/Outpatient Registration No: _____

Patient Identification No: _____

I, undersigned, hereby provide my consent and authorize

Liberty General Insurance Company Limited/ Appointed Administrator of Liberty General Insurance Company Limited

To Release Information Regarding My Health History, Allergies, Ongoing or Previous Health Conditions, and Current Health Status and/or Injuries to:

My employer, my insurance company/companies, service providers who may be involved in my care, and personal representatives or family member involved in my care

(Name of hospital/Doctor/Employee/Relative/Service Provider) ----------

To Release Information Regarding My Health History, Allergies, Ongoing or Previous Health Conditions, and Current Health Status and/or Injuries to:

Liberty General Insurance Company Limited/ Appointed Administrator of Liberty General Insurance Company Limited

Purpose of the Document:

Arrangement of your treatment, obtain the details of your treatment and payment details towards the same and run normal business of Liberty General Insurance Company Limited.

The Company is required legally to maintain the privacy of your medical information.

Date of Expiry: 365 days from the date of patient's signature.

If the authorization is signed by you, you will have complete right to revoke it anytime, to the extent that no action has been initiated based on this authorization.

You may in all circumstances refuse to sign this consent, in the event of which the Company will have limited ability to provide the contractual services to arrange for emergency medical services for you.

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be used or disclosed again by the recipient(s) and may no longer be protected by federal and state law.

You have a right to receive a copy of this form after you have signed it.

I have read this form and understand the importance of the same; all my queries in regards to this form are satisfactorily answered. I acknowledge that I have read and accept the above mentioned conditions, by signing below.

Patient signature: _____

Patient Name: _____ Date: DD/MM/YYYY

Parent/Guardian/Authorized Representative: _____

Relationship to the Patient: _____