TATA AIG INSURANCE
WITH YOU ALWAYS

MediCare | **MediCare** Premier | **MediCare** Protect | **MediCare** Plus
MediCare LITE | **Health** Supercharge | **MediCare** Select

Where to submit the claim

Health Claims Hub
TATA AIG General Insurance Co. Ltd.
Door No. 615, 616, 5th and 6th Floor
Imperial Towers, Ameerpet
Next to Ameerpet Metro Station
Hyderabad - 500016
Telangana.

How to track the claim

STEP 1
Open www.tataaig.com and click on Self Service

STEP 2
Login & choose search claims

STEP 3
Track claim status with the help of Policy Number/ Member ID/ Claim Number

Please submit complete documents as per the check list for speedy claim settlement.

CHECK-LIST

S.No.	Document	Yes	No	Type of document
1.	Copy of cancelled cheque for the proposer (Main Policy holder) - Account holder's name, account number and IFSC code should be printed on the submitted copy			Original/Photo Copy
2.	If the claimed amount is more than 1 Lakh; CKYC Form along with Photograph + PAN Card Copy of the Proposer + Address Proof			Original/Photo Copy
3.	Claim form - Please fill all the mandatory fields with appropriate information			Original/Photo Copy
4.	TATA AIG Health Card or Policy Copy			Original/Photo Copy
5.	ID, Address & Age Proof of the Patient			Original/Photo Copy
6.	Discharge/ Daycare Summary from the hospital indicating the presenting complaints, diagnosis, treatment given and past medical history			Original/Photo Copy
7.	Consolidated Final Bill along with breakup of the individual items			Original Mandatory
8.	Proof of payment paid at hospital - cash receipt			Original Mandatory
9.	In case of Implants being used - Please share relevant Invoice & Sticker			Original Mandatory
10.	Pharmacy & Lab Bills			Original Mandatory
11.	Diagnostic/ Lab Reports for submitted bills			Original/Photo Copy
12.	Doctor Prescriptions for submitted pharmacy bills			Original/Photo Copy
13.	Medical records and consultation papers prior to hospitalization			Original/Photo Copy
14.	Any previously approved settlement letter from other insurance (if any)			Original/Photo Copy
15.	In case of accidental injuries, please submit Medico-Legal Certificate (MLC) /First Information Report (FIR)			Original/Photo Copy
16.	In case of death of the proposer, details of nominee (as per policy schedule), along with address & ID proof of nominee			Original/Photo Copy
17.	Hospital Registration Certificate			Original/Photo Copy

Note: All financial documents (bills & receipts) should be submitted in original.

TYPE OF CLAIM (Please submit a different form for each type of claim)

- ☐ In-Patient Treatment
- ☐ Day Care Procedures
- ☐ Health Checkup
- ☐ High End Diagnostics
- ☐ OPD Treatment – Dental
- ☐ Maternity Cover
- ☐ Restore benefits
- ☐ OPD Treatment
- ☐ Daily Cash for choosing Shared Accommodation
- ☐ Pre & Post-Hospitalization expenses
- ☐ Others _____

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CLAIM FORM - Part A

To be filled in by the insured. The issue of this Form is not to be taken in as admission of liability. Please fill-up this form in CAPITAL LETTERS.

DETAILS OF PRIMARY INSURED (*Mandatory fields) (SECTION A)

Policy No.*: ☐☐☐☐☐☐☐☐☐☐ UHID: _____ Intimation Number: _____

Sl. No. / Certificate No*.: ☐☐☐☐☐☐☐☐☐☐ Company Name*: **TATA AIG General Insurance Company Ltd.**

Name*: _____
Prefix First Name Middle Name Last Name

Address*: _____

_____

Registered E-mail ID*: _____

Registered Phone Number*: ☐☐☐☐☐☐☐☐☐☐ Alternative Phone Number: ☐☐☐☐☐☐☐☐☐☐

DETAILS OF INSURANCE HISTORY (SECTION B)

i. Currently covered by any other Mediclaim/Health Insurance: Yes ☐ No ☐

ii. Have you been hospitalized in the last four years since inception of the contract? Yes ☐ No ☐

Date: _____ Diagnosis: _____

iii. Date of commencement of first insurance without break: _____

If yes, Company Name: _____

Policy No.: _____ Sum Insured (₹): _____

iv. Previously covered by any other Mediclaim/Health Insurance: Yes ☐ No ☐

If yes, Company Name: _____

Policy No.: _____ Sum Insured (₹): _____

DETAILS OF INSURED PERSON HOSPITALIZED (SECTION C)

Name: _____
Prefix First Name Middle Name Last Name

Gender: ☐ Male ☐ Female ☐ Other Date of birth: ☐☐☐☐☐☐☐☐ Age ☐☐ Years ☐☐ Months ☐☐

Relationship to Primary Insured: ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Father-in-law ☐ Mother-in-law ☐ Other (Please Specify) _____

Occupation: ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please Specify) _____

DETAILS OF HOSPITALIZATION (SECTION D)

Name of Hospital: where admitted _____

_____

Room Category occupied: ☐ Day Care ☐ Single Occupancy ☐ Twin Sharing ☐ 3 or more beds per room

Hospitalizaton due to: ☐ Injury ☐ Illness ☐ Maternity

Date of injury/Date Disease first detected/Date of Delivery: _____

Date of Admission: _____ Time: _____

Date of Discharge: _____ Time: _____

If Injury, give cause: ☐ Self Inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption

If Medico legal: Yes ☐ No ☐

Reported to police: Yes ☐ No ☐

MLC Report & Police FIR attached: Yes ☐ No ☐ (If yes, attach report)

System of Medicine ☐ Allopathy ☐ Other (Please Specify) _____

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DETAILS OF CLAIM (SECTION E)

Details of the treatment expenses claimed:		Details of Lump sum/cash benefit claimed:	
Type of claims	**Total expenses**	**Type of claims**	**Total expenses**
In-Patient Treatment		Critical Illness	
Pre & Post-Hospitalization Expenses		Accidental death benefits	
Day Care Procedures			
Health Checkup			
Daily Cash for choosing Shared Accommodation			
OPD Treatment			
OPD Treatment – Dental			
Maternity Cover			
High End Diagnostics			

Note: Please submit a different form for each type of claim

DETAILS OF BILLS ENCLOSED: (SECTION F)

S. No.	Bill No.	Date	Issued by	Towards	Amount	Total
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
				Grand Total		

Note: In case of multiple bills, you can attach a separate sheet.

Incase of delay in submitting the documents (Post 30days from Date of Discharge), please provide a separate covering letter with the reason for the delay.

DETAILS OF PRIMARY INSURED BANK ACCOUNT: (SECTION G)

PAN: ☐☐☐☐☐☐☐☐☐☐

Account No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Bank Name and Branch: _____

Cheque/DD Payable details: _____ IFSC Code: ☐☐☐☐☐☐☐☐☐☐☐

Please provide a Cancelled cheque of Proposer (with printed Payee Name)

DECLARATION BY THE INSURED (SECTION H)

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: _____ Signature of the Insured _____

Place: _____