PNB MetLife India Insurance Company Limited
Registered office: Unit No. 701, 702 & 703, 7th Floor, West Wing, Raheja Towers, 26/27 M G Road, Bangalore -560001, Karnataka. IRDA of India Registration number 117.
CI No. U66010KA2001PLC028883, Call us Toll-free at 1-800-425-6969, Website: www.pnbmetlife.com, Email: indiaservice@pnbmetlife.co.in or write to us at 1st Floor, Techniplex -1, Techniplex Complex, Off Veer Savarkar Flyover, Goregaon (West), Mumbai – 400062. Phone: +91-22-41790000, Fax: +91-22-41790203

HOSPITAL CASH BENEFIT CLAIM FORM

To be completed by Principal Insured (For Self and Minor Life) & Secondary Insured (For Self)

Note: PLEASE SIGN ON ALL PAGES AT BOTTOM

General instructions :

- **While answering questions in the claim form and providing any other information in respect of the claim, the Claimant must make a full and frank disclosure of all material facts.**
- **Please read the policy document carefully to avail the benefits under the policy.**
- **All corrections made in the claim form have to be duly countersigned in full.**
- **If the space provided is insufficient, please attach the annexures along with this form.**
- **Please submit the requisite documents along with the claim form for a faster processing.**
- **The company retains the right to call for further evidence needed to process the claim.**
- **Submission of form duly acknowledged by us does not amount to admission of claim.**
- **(*) Mandatory fields**

1. Particulars of Life Assured:

Policy Number*: _____

Name of the Life Assured*: _____

Name of the Principal Insured (In case the Life Assured is a Minor life or Secondary life):

_____

Date of Birth: _____ Sex: Male ☐ Female ☐

Address: _____

_____

Tel/Mobile number: _____ Email: _____

Do you want the payment to be made in favor of Principal Insured: Yes ☐ No ☐
(Applicable if Life Assured is Secondary Insured)

Claimant/ Principal Insured (As applicable) Bank account no.*: _____

Name of the Bank, Address *: _____

2. Particulars of Complaints and Symptom

I. Name, address & contact details of Hospital admitted: _____

_____

II. Reason for Hospitalization: _____

III. Date of disease (first diagnosis/surgery) : __ __ / __ __ / __ __ __ __ (DD/MM/YYYY)

IV. Date and time of admission: __ __ / __ __ / __ __ __ __ (DD/MM/YYYY) __ __ : __ __ (in 24 Hrs format)

V. Exact diagnosis /condition(s): _____

VI. Investigations undergone _____

VII. Date and time of discharge : __ __ / __ __ / __ __ __ __ (DD/MM/YYYY) __ __ : __ __ (in 24 Hrs format)

VIII. Details of occupation, address and tel. numbers of the employer(s) : _____

_____

IX. ICU Benefit Availed: Yes ☐ No ☐ Recuperation Benefit availed: Yes ☐ No ☐

X. Date and time of Admission into ICU: __ __ / __ __ / __ __ __ __ (DD/MM/YYYY) __ __ : __ __ (in 24 Hrs format)

XI. Date & time of Discharge from ICU: __ __ / __ __ / __ __ __ __ (DD/MM/YYYY) __ __ : __ __ (in 24 Hrs format)

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3. Following reports and documents taken before and during treatment or operation are enclosed:

a) **Copy of Admission Notes** ☐ b) **Copy of Discharge Summary** ☐

c) **Copy of Final Hospital Cash Paid Bill** ☐ d) **Any others. Please mention**: _____

(All above documents needs to be attested by Hospital Authorities or Original needs to be produced at Branch for verification by BSM)

4. Particulars of doctors consulted and hospital / medical centre wherein the Life Assured was admitted currently or for any other previous illness:

Sr. No	Name of the Doctors/Hospitals/ Medical Centres	Date of first consultation	Address	Registration no. of Doctors/ Hospitals	Date of Admission & operation	Date of Discharge

5. DECLARATION AND AUTHORISATION:

I _____ do solemnly declare and confirm that the foregoing answers and statements are true and complete in all respects.

I hereby authorize any medical practitioner or hospital or nursing home or medical clinic who or which has attended upon or examined or treated me/Life Assured for any ailment or illness to divulge any knowledge or information regarding my/Life Assured's state of health which he/she/they may have acquired before or after the issuance of the policy, to PNB MetLife India Life Insurance Co Ltd, any of its offices or a Court of law, or any grievance redressal forum. I hereby confirm that this authorization is notwithstanding any law, custom or usage for the time being in force prohibiting any physician or hospital from divulging any knowledge or information, acquired by him/ her/them in attending upon or examining a person on the ground of secrecy.

Further, I hereby authorize any insurance company, government organization, employer, other organization, institution or person to release to PNB MetLife India Insurance Company Ltd or its duly authorized representatives any record or knowledge about my/Life Assured. I hereby confirm that such information shall without limitation include information about my/Life Assured's health (including any information relating to the use of drugs or Alcohol, AIDS, or mental and physical history, condition, advice or treatment), earnings or other insurance benefits.

I hereby declare that I am entitled to make the above authorizations. I also agree to render help to P N B MetLife India Life Insurance Co Ltd or its duly authorized representatives to gather the said information or any information that may help the company to process this claim and to use the information in whatever manner as may be deemed to be fit in furtherance of the claim.

Signature / Thumb impression of the Claimant: _____

Place: _____ Date: _____

Signature of the Witness/Declarant:_____ Name of Witness/ Declarant: _____

Place: _____Date: _____

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6. VERNACULAR DECLARATION: (To be given if claim form is signed in vernacular or if the Claimant has used thumb impression instead of signature.)

I have explained the contents of this claim form to the Claimant in _____ _____ (language) and ensured that the contents have been fully understood by him/her. I have accurately recorded the Claimant's responses to the information sought in the claim form. I have read out the responses to the Claimant and he/she has confirmed that they are correct and affixed his/her thumb impression after fully understanding the same.

Signature of the Witness/Declarant:_____ Name of Witness/ Declarant: _____

Address: _____

Place: _____Date: _____
