SURGICAL CASH BENEFIT CLAIM FORM (SCBCF)

CLAIMS DOCUMENT CHECKLIST (CDCL)

Life Assured Name:

Policy No.:

- Please submit this form along with the requirements mentioned below at the nearest branch or address mentioned overleaf for faster processing of claim.
- Please note that all documents needs to be self attested.

Hospital Admission due to illness/surgery		
S.No.	**SCB Claim Requirements**	**Yes/No**
1.	Claim Form duly filled, signed by claimant and duly attested by an authorized person as mentioned in claim form	
2.	Authorization form duly filled and signed	
	Photocopy of policy schedule	
3.	Daily records of treatment during hospitalization	
4.	Discharge summary from the hospital stating the proper diagnosis and date & time of admission and discharge	
5.	All laboratory and pathology tests conducted such as blood reports	
6.	All investigative tests such as X-Ray, scans, MRI etc.	
7.	Relevant questionnaire duly filled (as per the format)	
8.	Declaration by the attending physician on the insured's current state of health	
9.	In case of surgery: surgical notes	
10.	Final hospital bill including details of room charges (ICU/Normal) and OT charges as well	
11.	Copy of cancelled cheque **(Mandatory)** with NEFT Mandate Form	
12.	Government approved identification proof	
13.	Copy of Claimant's current address proof	
In addition to the above documents if Hospital Admission is due to accident following additional documents need to be submitted.		
1.	Copy of First Information Report (FIR)	
2.	Police Final Report	
3.	Newspaper cutting	

AVIVA
Life Insurance

Aviva Life Insurance Company India Ltd.
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Registered Office: 2nd Floor Prakashdeep Building, 7, Tolstoy Marg New Delhi 110001 India

SURGICAL CASH BENEFIT CLAIM FORM (SCBCF)

1.Policy No.

Section I Details of the Life Insured

2.Name of Life Insured:

First Name Middle Name Surname

3. Current Residential Address : **(Current Address should match with Address proof provided)**

Pin Code:

Mobile no.:

Phone No. with STD Code:

E-mail ID:

4. Bank Account Details: **Please find enclosed NEFT Mandate Form**
(Please attach a copy of cancelled cheque and passbook copy along with this form)

5. Date of Birth:

6.Employment Details: Name of the Employer's /Business Name

Address :

Mobile or Phone no. : Exact nature of Job/ Business:

7. Reason for the claim: **Accident / Sickness / Pregnancy related complications.** (Please tick the relevant reason.)

Accident

Date & Time of Accident: Place of Accident:

How did the accident happen (Please provide full description)?

Was the accident reported to the police or to your employer? (Please Tick) Yes / No

If yes, please give details of the police station to which the matter was reported and attach copies of statements/ FIR taken by the police or your employer.

Were any other persons involved in the accident or responsible for the accident? (Please Tick) Yes /No

If yes, please give the name, address and contact numbers of the other persons involved or responsible.

Please provide the names, addresses and contact details of any witnesses who saw the accident occurred.

What part of the body was injured and what was the nature of injury? --

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Surgery

What is the surgery which you underwent? --

Date on which the first symptoms occurred? | | | | | | |

Briefly describe the symptoms from which you suffered and which resulted in this surgery

How long did you have these symptoms before you first consulted a doctor? --

When was the diagnosis of the surgery related to sickness made? ---

Pregnancy Related Complications

Date on which the first symptoms of the pregnancy related complications occurred | | | | | | |

In which pregnancy week are you now? ---

Hospitalization and Treatment

Date on which medical treatment was started | | | | | | |

What treatment was prescribed? ---

Prior to the current period of hospitalization, have you ever been treated in the past for this sickness or accident or any related medical conditions? Yes/No

If Yes, please provide details below & enclose consultation notes, discharge summary, hospital reports available with you.

Name of Hospital where Life Insured was recently hospitalized---

What was the name of the doctor who referred you to hospital? --

When did the hospitalization start and end? **(Provide date and timings)**

General/ normal ward--- **ICU/CCU---**

Was surgery performed for this condition? Yes /No If 'Yes' please provide details with hospital records.

Is further surgery required? Yes/ No

If yes, when is this planned? ------------------------ Details of surgery planned ---

Was any home leave taken during the period of hospitalization? Yes / No

If Yes, on which dates, Were you referred to any other clinic or hospital. If so, please provide the name of the clinic or hospital, dates of admission and discharge? --

Describe treatment, medication and therapy undertaken since hospital discharge? ---

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Doctor Information

Who was the attending physician when you were in hospital? --

Please tell us the names of other doctors/ hospitals/ clinics or other medical professionals (e.g. physiotherapists) who attended you for this illness and dates of consultations? ---

Details of Other Insurance Policies on the life of Life Insured

Policy No.	Sum Assured	Name of Insurance Company/Employer Name	Date of Commencement	Type of Plan

Have you previously received reimbursement for this accident, illness, or pregnancy from any other company? Yes / No. If Yes, what is the name and address of the company?

Declaration and authorisation

1. I/ we hereby declare that the answers given by me in this form are in all respects truthful and correct. No material information has been withheld. The company is authorised to obtain any information in connection with this claim from any source and I/ We hereby authorise the obtaining of such information. A photocopy of this authorisation shall be as valid as the original.

2. I/ We hereby declare and agree that any personal information collected or held by Aviva Life Insurance (whether contained in this claim form or otherwise obtained) may be held, or disclosed by the Company to persons or organisations associated with the Company or to selected third parties including reinsurance and claims investigation companies or industry associations to meet any legislative requirement.

3. I/ We Authorise that my/our personal information may be provided to Aviva Life Insurance by any medical practitioner, hospital and clinic, employer, institutions, or any other person or persons including any and all information about my/our health, medical history, hospitalisation, advice, diagnosis, treatment, disease or ailment. I/ We also consent to a personal medical investigation as part of my/our claim.
4. As well, I/ We understand we have the right to obtain access to and to request correction of any personal information held by the Company concerning me/ us. (If you wish to make such a correction, please refer to our Customer Service Centres).

Date: Signature of Life Insured..

AUTHORISATION

(To be filled & signed by the Life Assured)

Life Insurance Policy No.(s) ___________________________________

I, Mr. / Mrs / Ms. ____________________________________ *(name of the Life Assured)*, hereby give my consent to M/s Aviva Life Insurance Company India Limited, and / or its representative to obtain all employment / medical / hospital records / police records / other records (including photocopies) / information pertaining to my treatment / occupation which I might have acquired whether before or after the policy was issued by the Company as well as details from other Life Insurance Companies regarding any existing policies which I may have sourced before or after the initiation of this contract.

Date: Yours faithfully

Place:

(Signature of Claimant)

Contact details of the claimant:

Address:

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____

____

____

____

Pin: __________________

Landline: STD Code _______ No. ____________

Mobile No.: _________________

Email id:..

NEFT Mandate Form: Direct Transfer of Claim amount to your

Mandatory: Copy of cancelled cheque bearing the below mentioned account number along with this form .

To,
AVIVA life Insurance Company India Limited,

Sub: E-Payments vide NEFT

I/We request and authorize you to effect E-payment vide NEFT mode to my/our Bank account as per the details given below:

Full name of the Claimant:

First Name Middle Name Surname

Full name of the Bank Account Holder as appearing in the Account:

First Name Middle Name Surname

Bank Account No.:

Bank Name: ______________________________

Bank Address (Including State, City, Pin Code): ______________________________

____

Bank Branch contact persons' names and Tele nos with STD Code: ______________________________

Account Type: ☐ Saving Account ☐ Current Account

Bank Branch IFSC Code No. (Mandatory for NEFT): ______________________________

Bank Branch MICR Code: ______________________________

I/We confirm that information provided above is correct and any consequences due to any mistake in above will be borne by me.

Thanking You,

Name & Signature of the Claimant: ______________________________

Bank Verification:

We confirm that we are enabled for receiving for NEFT credits and we further confirm that the account number of the.. and the signature of the authorised signatory and the IFSC and MICR codes of our branch mentioned above are correct.

Bank verification Stamp with branch address and Signature of the Banker ______________________________

Name of the Signing authority ______________________________

ACKNOWLEDGEMENT SLIP

Policy No.: | | | | | | | | | | |

Name of Claimant: ……………………………………………………………………………..

Interaction ID:…………………………………………………...

Documents Submitted: Please Tick

- ☐ SCB Claim Form and Authorisation Form Signed by the Claimant
- ☐ Photocopy of policy schedule
- ☐ Daily records of treatment during hospitalization
- ☐ Discharge summary from the hospital stating the proper diagnosis and date & time of admission and discharge
- ☐ All laboratory and pathology tests conducted such as blood reports
- ☐ All investigative tests such as X-Ray, scans, MRI etc.
- ☐ Relevant questionnaire duly filled (as per the format)
- ☐ Declaration by the attending physician on the insured's current state of health
- ☐ In case of surgery: surgical notes
- ☐ Final hospital bill including details of room charges (ICU/Normal) and OT charges as well
- ☐ Copy of cancelled cheque **Mandatory with NEFT Mandate Form**
- ☐ Government approved identification proof
- ☐ Copy of Claimant's current address proof
- ☐ Copy of First Information Report (FIR)
- ☐ Police Final Report
- ☐ Newspaper Cutting

Processed by (Name & Signature):

BRANCH STAMP WITH RECEIPT DATE:

Claim Contact Points

Mailing Address:	For any urgent queries contact:	For any queries please write to:
Aviva Life Insurance Company India Ltd. 3rd Floor. Aviva Towers, Sector-43, Opposite DLF Golf Course, Gurgaon-122003	Customer service Helpline Number 1800-180-22-66 (Toll Free) 0124-2709046	claims@avivaindia.com

Claim/SCBCF/Ver1.0/1stApr2011