



HOSPITAL CASH BENEFIT CLAIM FORM (HCBCF)
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.	HCB Claim Requirements	Yes/No
1.	Authorization form duly filled and signed	
2.	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	



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HOSPITAL CASH BENEFIT CLAIM FORM (HCBCF)

1. Policy No.

2. Name of Life Insured: Section I Details of the Life Insured

First Name	Middle Name	Surname
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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
Mandatory (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

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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)?

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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? -----

Sickness

What is the sickness from which you suffer? -----

Date on which the first symptoms occurred?

Briefly describe the symptoms from which you suffered and which caused this hospitalization.

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

When was the diagnosis of the 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? -----



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:

Pin: _____

Landline: STD Code _____ No. _____

Mobile No.: _____

Email id:.....



NEFT Mandate Form: Direct Transfer of Claim amount to your Bank

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:

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First Name

Middle Name

Surname

Bank Account No.

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

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First Name

Middle Name

Surname

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.:

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Name of Claimant:

Service Request ID:.....

Documents Submitted: Please Tick

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