



HANDOUT –RIDER CLAIMS (HRC)

KIND ATTENTION: CLAIMANT

At Aviva, we value the relationship with our customers. We assure you of our support through the rider claims process to complete the formalities for the same.

We would like to inform you that we would require the following documents in order to settle your claim at the earliest. Request you to go through the documents mentioned below carefully, along with the specific instructions mentioned, which will help you in submission of these at the earliest.

1. **Rider Claim Form**- Please fill in each point correctly and provide details wherever required. This form has to be filled and signed by the claimant in his/her own handwriting. In case of Payor Rider/ Critical Illness/ Accidental Dismemberment/ Permanent Total Disability/ Dreaded Disease, claim form has to be attested by the persons as mentioned in the form.
2. **Original Policy Documents and Schedule**-Please submit the Policy Document and schedule which was sent and provided at the time of commencement of the policy in case of Payor Rider/ Critical Illness/Permanent Total Disability. However in case of Hospital Cash Benefit , Accidental Dismemberment , Dreaded Disease claim, a Xerox of Policy schedule will suffice.
3. **Lost Original Policy Documents and Schedule** -In case the policy documents & Schedule is lost, please intimate us assigning the reason and explaining the circumstances in which it was lost. An indemnity on Rs.100/- stamp paper duly executed, signed, witnessed and notarized needs to be submitted along with attested ID proof and address proof of the Life Insured.
4. **Daily records from Treating Hospital** – Records that are maintained on a daily basis during the duration of hospitalization of the Life Assured in the treating hospital are required. The same will have to be obtained in Xerox from the concerned hospital.
5. **Discharge Summary** – Issued by the concerned hospital where Life assured had taken last treatment.
6. **Timings and Hospital status**: Please submit exact timing of admission and discharge from the hospital along with the number of beds in the hospital and registration details on the letterhead of the hospital.
7. **All laboratory and pathology test reports** – All blood and biochemistry reports / tests undergone prior to / during and prior and after the admission in hospital need to be submitted.
8. **All investigative test reports** - Reports of all major tests such as X-Ray, CT scans, MRI which are handed over to patient on discharge from the hospital.
9. **Relevant questionnaire duly filled (as per the format)** - To be filled by the Doctor / Hospital who has treated the Life Assured or has provided the treatment during hospitalization or just prior to admission in the format attached.
10. **Other hospital papers**-Treatment Records of Life Assured for any illness in the past / during current admission.
11. **Hospital Authority Letter**-As per Terms & conditions of the policy, we would require this authorization from you
12. **Declaration by the attending physician on the insured's current state of health** – A certificate issued by the treating doctor / hospital at the time of discharge indicating claimant's health at present.
13. **Final hospital bill including details of room charges (ICU/Normal)** – In case of Hospital Cash Benefit claims final hospital bill is required incorporating the exact details of number of days of admission of patient in ICU or Normal Ward separately.
14. **FIR and Police Inquest Report**-To be obtained from Police Authorities-In case FIR has been lodged and Police Inquest has been done or in process, especially, in case of accidents.
15. **Identification proof of the policyholder/Life insured** - Photo ID proof issued by Government Authorities.
16. **Age Proof of the LA** - Kindly submit the age proof of Life Assured, if not submitted at the time of proposal,
17. **NEFT Mandate Form** – To make direct transfer of claim payment to your account, please provide NEFT Mandate Form along with copy of cancelled cheque (Mandatory) bearing IFSC code, Bank account number and name of the claimant. If the cancelled cheque copy does not contain the information asked for, please provide the passbook copy along with cancelled cheque copy.
18. **Current Address Proof of the nominee** – Please provide relevant address proof for the address mentioned in the claim form.
19. **Contact number of the claimant** - Please provide the correct Mobile/ Landline number

Should you have any queries or clarifications during the process of submission of the above documents, you can write to us at claims@avivaindia.com or contact your nearest Aviva branch (list of branches are also available on our website www.avivaindia.com). Alternatively you contact our Customer Service Helpline number **1800-103-77-66/ 0124-2709046** (Monday to Saturday, 8AM to 8PM).

Our mailing address is as follows

Claims Department,

Aviva Life Insurance Company India Limited,

Aviva Tower, Sector Road, Opp. Golf Course, DLF phase-V, Sector 43, Gurgaon-122003

Tele No-91-124-2709046, Fax-91-124-2571205

Claim/HBCF /Ver1.0/1stApr2011



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	



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?

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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

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In which pregnancy week are you now? -----

Hospitalization and Treatment

Date on which medical treatment was started

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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? -----

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:

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
- 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

<p>Mailing Address:</p> <p>Aviva Life Insurance Company India Ltd. Aviva Towers, Sector-43, Opposite DLF Golf Course, Gurgaon-122003 Haryana</p>	<p>For any urgent queries contact:</p> <p>Customer service Helpline Number 1800-103-77-66 (Toll Free)</p> <p style="text-align: center;">0124-2709046</p>	<p>For any queries please write to:</p> <p style="text-align: center;">claims@avivaindia.com</p>
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