

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.	<u>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</u>			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)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> In-Patient Treatment | <input type="checkbox"/> Day Care Procedures | <input type="checkbox"/> Health Checkup | <input type="checkbox"/> High End Diagnostics |
| <input type="checkbox"/> OPD Treatment - Dental | <input type="checkbox"/> Maternity Cover | <input type="checkbox"/> Restore benefits | <input type="checkbox"/> OPD Treatment |
| <input type="checkbox"/> Daily Cash for choosing Shared Accommodation | <input type="checkbox"/> Pre & Post-Hospitalization expenses | | |
| <input type="checkbox"/> Others _____ | | | |

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: _____

To be filled in by the Hospital. The issue of this Form is not to be taken as an admission of liability. Please include the original pre-authorization request form in lieu of PART A.

Please fill-up this form in CAPITAL LETTERS.

DETAILS OF HOSPITAL

(SECTION A)

Name of the Hospital: _____

Type of Hospital: Network Non-network (If non-network fill Section D) Valued Provider-Pan India

ROHINI ID: _____

Facilities available in the hospital: OT: ICU:

Name of the treating Doctor: _____
Prefix First Name Middle Name Last Name

Qualification: _____ Phone No.:

Registration No.: _____
 (with State Code)

DETAILS OF THE PATIENT ADMITTED

(SECTION B)

Name of the Patient: _____
Prefix First Name Middle Name Last Name

IP Registration Number: _____ Gender: M F Age: Years Months

Date of Birth: Date of Admission: Time: _____

Date of Discharge: Time: _____

Type of Admission: Emergency Planned Day Care Maternity

If Maternity: i) Date of Delivery: _____ i) Gravida Status: G P L A

Status at time of discharge: Discharge to home Discharge to another hospital Deceased

Total claimed amount ₹ :

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

(SECTION C)

ICD 10 Codes:	Description	ICD 10 PCS:	Description
i) Primary Diagnosis	_____	i) Procedure 1	_____
ii) Additional Diagnosis	_____	ii) Procedure 2	_____
iii) Co-morbidities	_____	iii) Procedure 3	_____
iv) Co-morbidities	_____	iv) Details of Procedure	_____

Pre-authorization obtained: Yes No Pre-authorization Number:

If authorization by network hospital not obtained, give reason: _____

Hospitalization due to injury: Yes No

i) If yes, give cause: Self-inflicted Road Traffic Accident Substance abuse / alcohol consumption

ii) If injury due to Substance abuse/alcohol consumption, Test Conducted to establish this: Yes No (If Yes, attach report)

iii) If Medico legal: Yes No iv) Reported to Police: Yes No v) FIR No.:

vi) If not reported to police, give reason: _____

With reference to IRDAI Circular No. IRDAI/SDD/MISC/CIR/135/07/2016, KYC details are required for Individual/ Retail policy holders, if the total claimed amount exceeds ₹ 100,000

CENTRAL KYC REGISTRY | Know Your Customer (KYC) Application Form | Individual

Important Instructions:

- A) Fields marked with '*' are mandatory fields.
- B) Tick '✓' wherever applicable.
- C) Please fill the form in English and in BLOCK letters.
- D) Please fill the date in DD-MM-YYYY format.
- E) Please read section-wise detailed guidelines / instructions at the end.
- F) For a particular section update, please tick (✓) in the box section number and strike off the sections not required to be updated.
- G) List of State / U.T code as per Indian Motor Vehicle Act, 1988 is available at the end.
- H) List of two character ISO 3166 country codes is available at the end.
- I) KYC number of applicant is mandatory for update application.
- J) The 'OTP based E-KYC' check box is to be checked for accounts opened using OTP based E-KYC in non-face to face mode



For office use only (To be filled by financial institution)

Application Type* New Update

KYC Number (Mandatory for KYC update request)

Account Type* Normal Minor Aadhaar OTP based E-KYC (in non-face to face mode)

1. PERSONAL DETAILS* (Please refer instruction A at the end)

Name* (Same as ID proof)

Prefix	First Name	Middle Name	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Maiden Name	<input type="text"/>	<input type="text"/>	<input type="text"/>
Father / Spouse Name	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mother Name	<input type="text"/>	<input type="text"/>	<input type="text"/>

Date of Birth* Gender* M- Male F- Female T-Transgender

Pan* Form 60 furnished

2. PROOF OF IDENTITY AND ADDRESS* (Please refer instruction B at the end)

I. Certified copy of OVD or equivalent e-document of OVD or OVD obtained through digital KYC process needs to be submitted (anyone of the following OVDs)

- A- Passport Number
- B- Voter ID Card
- C- Driving Licence
- D- NREGA Job Card
- E- National Population Register Letter
- F- Proof of Possession of Aadhaar

- II. E-KYC Authentication
- III. Offline verification of Aadhaar

PHOTO*



Address

Line 1*

Line 2

Line 3 City / Town / Village*

District* Pin / Post Code*

State / U.T Code* ISO 3166 Country Code*

3. CURRENT ADDRESS DETAILS (Please refer instruction B at the end)

Same as above mentioned address (In such cases, address details as below, need not be provided)

I. Certified copy of OVD or equivalent e-document of OVD or OVD obtained through digital KYC process needs to be submitted (anyone of the following OVDs)

- A- Passport Number B- Voter ID Card
- C- Driving Licence
- D- NREGA Job Card

- E- National Population Register Letter
- F- Proof of Possession of Aadhaar
- II. E-KYC Authentication
- III. Offline verification of Aadhaar
- IV. Deemed Proof of Address - Document Type Code

Address

Line 1*

Line 2

Line 3 City / Town / Village*

District* Pin / Post Code*

State / U.T Code* ISO 3166 Country Code*

4. CONTACT DETAILS (All communication will be sent to Mobile number/ Email-ID provided) (Please refer instruction C at the end)

Tel. (Off) - Tel. (Res) -

Email ID Mobile

5. REMARKS (If any)

6. APPLICANT DECLARATION

- I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it.
- I hereby consent to receiving information from Central KYC Registry through SMS/Email on the above registered number/email address.

[Signature / Thumb Impression]

Signature / Thumb Impression of Applicant

Date: Place:

7. ATTESTATION / FOR OFFICE USE ONLY

- Documents Received** Certified Copies E-KYC data received from UIDAI Data received from offline verification
- Digital KYC Process Equivalent e-document Video Based KYC

KYC VERIFICATION CARRIED OUT BY

Date

Emp. Name

Emp. Code

Emp. Designation

Emp. Branch

[Employee Signature]

INSTITUTION DETAILS

Name

Code

[Institution Stamp]

To know more about Instructions / Checklist / Guidelines for filling Individual KYC Application Form, please visit E-KYC website.