





**(H) DETAILS OF THE LIFE ASSURED'S HABITS:**

<b>a.</b>	Substance	<b>b.</b>	Forms of Consumption	<b>c.</b>	Quantity	<b>d.</b>	Duration
	Alcohol		<input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Whiskey		Per Day _____ ml <input type="checkbox"/> Bottle <input type="checkbox"/>		
	Tobacco		<input type="checkbox"/> Others <input type="checkbox"/> Please Specify		_____ No. of Sticks <input type="checkbox"/> Packets <input type="checkbox"/>		
			<input type="checkbox"/> Cigarettes <input type="checkbox"/> Beedis				
			<input type="checkbox"/> Chewing Tobacco				
<b>e.</b>	Others Please Specify: _____						

Were you required to be away from work due to this condition/habits?  Yes  No

If yes, please provide details of time away from work (dates, duration): \_\_\_\_\_

**(I) HOSPITALISATION AND CONSULTATION DETAILS: (if the space provided is inadequate, kindly attach annexures)**

Sr. No	Name of the Hospital/Doctor	Contact Details of Hospital/Doctor	Dates of Consultation/Admission & Discharge	Diagnosis
1				
2				
3				
4				
5				

**(J) DETAILS OF BILLS ENCLOSED**

SL. No.	Bill No.	Date	Issued by	Towards	Amount (INR)
1		D D M M Y Y		Hospital Main Bill	
2		D D M M Y Y		Pre-hospitalisation Bill: No's	
3		D D M M Y Y		Post-hospitalisation Bill: No's	
4		D D M M Y Y		Pharmacy Bills	
5		D D M M Y Y			
6		D D M M Y Y			
7		D D M M Y Y			
8		D D M M Y Y			
9		D D M M Y Y			
10		D D M M Y Y			

**(K) DETAILS OF PRIMARY INSURED'S/CLAIMANT'S BANK ACCOUNT**

**a.** PAN:

**b.** Account Number:

**c.** Bank Name and Branch:

**d.** Cheque/DD Payable Details: \_\_\_\_\_ **e.** IFSC Code:

**f.** Attested Photocopy Attached for:  Cancelled Personalised Cheque  Latest Bank Statement (not more than 3 months old)

Copy of Pass Book (indicating Account Number & IFSC Code)

**(L) DECLARATION BY THE INSURED/CLAIMANT:**

I hereby declare that the information furnished in this claim is true and 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 Cancer Care benefit shall be forfeited. I also agree and authorise TPA/Insurance company, to seek necessary medical information/documents from any hospital/medical practitioner who has attended to 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 and that I will not be making any supplementary claim.

I/We, the Life Assured acknowledge and declare the receipt of the entire amount due and payable under the Policy mentioned above towards the full and final settlement of the claim. I/We declare that HDFC Life is discharged of all the liabilities under the said Policy.

Date:       Place: \_\_\_\_\_

Signature of the Insured/Claimant: \_\_\_\_\_

Rs. 1/-  
Revenue Stamp

Please sign across the revenue stamp



## GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled by the Insured/Claimant)

DATA ELEMENT	DESCRIPTION	FORMAT
<b>SECTION B – DETAILS OF INSURANCE HISTORY</b>		
Diagnosis	Enter the diagnosis details	Open Text
e. Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim/ Health Insurance	Tick Yes or No
f. Company Name	Enter the full name of the insurance company	Name of the organisation in full
Policy No.	Enter the Policy number	As allotted by the insurance company
Sum Insured	Enter the total Sum Insured as per the Policy	In INR
Benefit Type	Enter the benefits covered as per the Policy	Tick the relevant
Date of commencement of first insurance without break	Enter the date of first insurance cover commencement	Use dd-mm-yy format
Claim status	Indicate the status of claims made under the Policy	Tick the relevant
Any other information	Enter any other previous insurance details	Open Text

**SECTION C – DETAILS OF INSURED PERSON HOSPITALIZED**

a. Name	Enter the full name of the patient	Surname, First name, Middle name
b. Gender	Indicate Gender of the patient	Tick Male or Female
c. Age	Enter age of the patient	Number of years and months
d. Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e. Relationship with primary Insured	Indicate relationship of patient with Policyholder	Tick the right option, if others, please specify
f. Occupation	Indicate occupation of patient	Tick the right option, if others, please specify
Nature of Work	Indicate the nature of occupational duty	Open Text
Employer Name	Enter the employer name	Open Text
Employer Address	Enter employer address	Include street, City and Pin Code
Employer Contact Details	Enter employer contact details	Complete contact details
g. Address	Enter the full postal address	Include street, City and Pin Code
h. Phone No.	Enter the phone number of patient	Include STD code with telephone number
i. E-mail ID	Enter e-mail address of patient	Complete email address

**SECTION D – DETAILS OF HOSPITALISATION**

a. Name of Hospital where Insured	Enter the name of hospital	Name of hospital in full
b. Room category occupied	Indicate the room category occupied	Tick the right option
c. Hospitalisation due to	Indicate reason of hospitalisation	Tick the right option
d. Date of Injury / Date when disease first detected / Date of delivery	Enter the relevant date	Use dd-mm-yy format
e. Date of admission	Enter date of admission	Use dd-mm-yy format
f. Time	Enter time of admission	Use hh:mm format
g. Date of discharge	Enter date of discharge	Use dd-mm-yy format
h. Time	Enter time of discharge	Use hh:mm format
i. If injury, give cause	Indicate cause of injury	Tick the right option
If Medico-legal	Indicate whether injury in medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No

## GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled by the Insured/Claimant)

DATA ELEMENT	DESCRIPTION	FORMAT
<b>SECTION D – DETAILS OF HOSPITALISATION</b>		
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j. System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
k. Type of Cancer	Indicate type of cancer	Tick the right option
<b>SECTION E – DETAILS OF CLAIM</b>		
a. Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In INR (Do not enter paise values)
b. Claim for Domiciliary Hospitalisation	Indicate whether claim is for domiciliary hospitalisation	Tick Yes or No
c. Details of lump sum/cash benefit claimed	Enter the amount claimed as lump sum /cash benefit	In INR (Do not enter paise values)
d. Claim Documents Submitted–Check List	Indicate which supporting documents are submitted	Tick the right option
<b>SECTION F – CLAIMED CONDITION DETAILS</b>		
a. Final Diagnosis	Indicate reason of hospitalisation	Open Text
b. Date of Diagnosis	Enter the date diagnosis	Use dd-mm-yy format
c. Date of First Doctor Consultation	Enter the date on which a doctor was first consulted	Use dd-mm-yy format
d. Nature and Duration of Complaints Necessitating Medical Attention:	Describe the complaints in detail along with duration of each	Open Text
e. Date when These Complaints First Became Evident:	Enter date on which the complaints were first noticed	Use dd-mm-yy format
f. Site of Tumour	Indicate the location of the cancerous tumour	Open Text
<b>SECTION G – PAST HEALTH HISTORY OF LIFE ASSURED</b>		
a. Any Other Illness/Surgery Prior to the Current Illness	Indicate the previous medical/surgical history of Life Assured	Open Text
b. Date when this Illness was First Detected	Enter the date on which the previous illness or disease was detected	Use dd-mm-yy format
c. Any Previous Malignancy or Pre-Malignancy Conditions	Indicate whether there is a previous history of malignancy or pre-malignancy	Tick Yes or No
d. If Yes, Please Provide Details	Describe the previous history of malignancy or pre-malignancy	Open Text
<b>SECTION H – DETAILS OF THE LIFE ASSURED'S HABITS</b>		
Indicate the Life Insured's Habits		
<b>SECTION I – HOSPITALISATION AND CONSULTATION DETAILS</b>		
Indicate the Life Insured's past and current hospitalisation and doctor consultation details		
<b>SECTION J – DETAILS OF BILLS ENCLOSED</b>		
Indicate which bills are enclosed with the amounts in rupees		
<b>SECTION K – DETAILS OF PRIMARY INSURED'S BANK ACCOUNT</b>		
a. PAN	Enter the permanent account number	As allotted by the Income Tax department
b. Account Number	Enter the bank account number	As allotted by the bank
c. Bank Name and Branch	Enter bank name along with the branch	Name of the bank in full
d. Cheque/DD payable details	Enter the name of the Beneficiary in whose favour the cheque/DD will be issued	Name of the individual/organisation in full

## GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled by the Insured/Claimant)

DATA ELEMENT

DESCRIPTION

FORMAT

## SECTION K - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

e. IFSC Code

Enter the IFSC code of the bank branch

IFSC code of the bank branch in full

## SECTION L - DECLARATION BY THE INSURED/CLAIMANT

Read the declaration carefully and mention the date (in dd:mm:yy format), place (open text), fix Re 1 revenue stamp and sign.

## SECTION M - AUTHORISATION BY THE INSURED/CLAIMANT

Read the authorisation carefully and mention the date (in dd:mm:yy format), place (open text), relationship with the Life Assured and sign.

## SECTION N - WITNESS ATTESTATION/DECLARATION

Read authorisation carefully and mention the date (in dd:mm:yy format), place (open text), relation to Life Assured and sign.

## NOTE

With reference to recent regulatory changes, please submit PAN or Form 60 (if you do not have a PAN) with HDFC Life with immediate effect. Please update via My Account/service@hdfclife.com/ 022-68446530/HDFC Life branch. Ignore if submitted.

**HDFC Life Insurance Company Limited (HDFC Life).** CIN: L65110MH2000PLC128245. IRDAI Registration No. 101.

**Regd. Off:** 13th Floor, Lodha Excelus, Apollo Mills Compound, N.M. Joshi Marg, Mahalaxmi, Mumbai - 400 011.

For queries or more information, call **022-68446530** (STD charges apply). Available Mon-Sat from 10 am to 7 pm.

DO NOT prefix any country code, e.g. +91 or 00. Email – **service@hdfclife.com** | **nriservice@hdfclife.com** (For NRI customers only) | Visit – **www.hdfclife.com**