

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.	Copy of cancelled cheque for the proposer - Account holder's name, account number and IFSC code should be printed on the submitted copy			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) 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: _____

ADDITIONAL DETAILS IN CASE OF NON-NETWORK HOSPITAL
(ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

(SECTION D)

Name of the Hospital: _____

Address: _____

City/Town _____ District _____

Pin Code State _____

E-Mail _____ Phone

Registration No.: _____ Hospital PAN: Number of In-patient beds: _____

with State Code

Facilities available in the hospital: i) OT: Yes No ii) ICU: Yes No iii) Others _____

DECLARATION BY THE HOSPITAL
(PLEASE READ VERY CAREFULLY)

(SECTION E)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: _____

Place: _____

Signature and Seal of the Hospital Authority: _____

Communication details of TPA (kindly submit the duly signed, filled claim form along with original documents at the following address)

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, Phone-040-66864900. Toll-Free: 1800 266 7780 or 1800 229 966 (For Senior Citizens). Website: www.tataaig.com. Email: healthclaimsupport@tataaig.com

Prohibition of Rebates - Section 41 of Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Insurance is the subject matter of solicitation. For more details on risk factors, terms and conditions, please read sales brochure carefully, before concluding a sale.

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*	<input type="text"/>	Gender* <input type="checkbox"/> M- Male <input type="checkbox"/> F- Female <input type="checkbox"/> T-Transgender	
Pan*	<input type="text"/>	<input type="checkbox"/> 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.



POLICY DECLARATION FORM

Date:.....

Name of the Hospital :.....

Address:.....

PATIENT NAME (BLOCK LETTERS):..... AGE/SEX :.....

Mobile No of Patient:.....

Date of Admission:..... Date of Discharge:.....

Undertaking by the Patient regarding Health Insurance Policy

(स्वास्थ्य बीमा पॉलिसी के संबंध में रोगी द्वारा शपथ-पत्र)

- I have not declared about any health insurance policy, at the time of Hospital admission.
(मैं सुचित करता हूँ कि अस्पताल में उपचार के दौरान मेरे पास कोई भी स्वास्थ्य बीमा पॉलिसी नहीं है।)

Signature: (हस्ताक्षर)

Name of the Patient/Patient's attendant (मरीज का नाम)

- I have declared about the health insurance policy, at the time of Hospital admission.
(मैं सुचित करता हूँ कि अस्पताल में उपचार के दौरान मेरे पास स्वास्थ्य बीमा पॉलिसी है,

Signature: (हस्ताक्षर)

Name of the Patient/Patient's attendant (मरीज का नाम)

Undertaking by the Hospital

Based on patient undertaking hospital declare that patient: (रोगी के उपक्रम के आधार पर हम उस रोगी की घोषणा करते हैं)

- Patient did not declare any health insurance coverage, at the time of hospital admission. Hence we will bill the patient as per our rack rates. We may or may not consider discount for all such undertakings. (स्वास्थ्य बीमा कवरेज नहीं है, अस्पताल में भर्ती के समय। इसलिए हम मरीज को अपनी रैक दरों के अनुसार बिल देंगे। हम ऐसे सभी उपक्रमों के लिए छूट पर विचार कर भी सकते हैं और नहीं भी।)
- Patient declared health insurance coverage, at the time of hospital admission. But out of own free will is opting for reimbursement/ cash paying mode. . As insured is already covered under TPA servicing for which we are network provider, hence we agree to bill this patient as per PHS or insurer agreed rate list (whichever is less). The benefit of discount as per MOU will also be given to this patient. (रोगी के पास स्वास्थ्य बीमा कवरेज है, अस्पताल में भर्ती के समय। लेकिन वह अपनी मर्जी से रीडंबसमेंट/नकद भुगतान मोड का विकल्प चुन रहा है। . चूंकि बीमित व्यक्ति पहले से ही टीपीए सर्विसिंग के अंतर्गत कवर है जिसके लिए हम नेटवर्क प्रदाता हैं, इसलिए हम इस मरीज को पीएचएस या बीमाकर्ता द्वारा सहमत दर सूची (जो भी कम हो) के अनुसार बिल देने के लिए सहमत हैं। एमओयू के अनुसार छूट का लाभ भी इस मरीज को दिया जायेगा.)

Signature:

Name of the Hospital Representative & Hospital Seal