भारतीय जीवन बीमा निगम
LIFE INSURANCE CORPORATION OF INDIA

Request for Quick-Cash Facility on Major Surgical Benefit under LIC's Health policies (excluding 901, 902 plans)

To be filled in by the Insured/Patient / Dependant adult family member: (All fields are mandatory for filling up)

1.	Name of the Insured / Patient	
2.	Age:	3. Sex: M / F — 4. Mobile No:
5.	Policy Numbers 1. 2.	
6.	Health Card No.	
7.	Your T.P.A.'s Name	
8.	Name of your family doctor & his / her mobile No	
9.	Details of the Bank A/c in to which the Policyholder / claimant desires LIC to transfer the Advance amount	9.(a).Name of the Bank-- ---------- (f).IFSC NO*---------- *The eleven digit number that will enable payments through RTGS/NEFT electronic transfe (b).Location ---------- (c).Branch Code ---------- (d).A/C NO---------- (e) MICR No.----------r

To be filled by the Treating Doctor/Hospital

10. Name & Address of the Hospital	
11. Name of the Treating Doctor & Registration No:	12. Mobile No. of treating doctor
13. Nature of Illness/Disease with present complaints	14. Duration of present Ailment / Illness
15. Date of first consultation and earlier history of present ailment, if any	16. Relevant clinical examination findings:
18 (a)Provisional / Clinical Diagnosis:	18 (b). ICD 10 code

19 Proposed line of treatment: Medical management / Surgical management
Investigation / Intensive care / Non-allopathic treatment / Palliative treatment / Rehabilitation treatment / Supportive care and Observation.

20(a)If Surgical intervention planned: Name of the Surgery & its detailed description	20(b) ICD 10 PCS Code

21 Is the Surgery required in consequence of any Pre-existing disease or Congenital condition? Yes / No
If Yes, give the full details of the condition and duration:

22 For any additional treatments, please furnish full details:

23 (a). How did the injury occur (in case of accidents only):	24 (a). Is it due to a RTA? Y / N 24(b). FIR / MLC attached? Y / N 24(c). Alcohol/Drug intoxication? Y / N

25 (a) Any Past history of Hypertension OR High blood pressure OR Diabetes OR Cardiovascular disease OR Genito-urinary disease?	Yes / No	If **Yes**, give duration in (Weeks, Months or Years)
25 (b) Any Past history of Cancer of any type OR Mental Disorder OR Endocrine Diseases OR Digestive diseases OR respiratory diseases?	Yes / No	
25 (c) Any Past History of any Musculoskeletal diseases OR Neurological disease?	Yes / No	

26. Date & time of admission in Hospital:	d d m m y y y y — h h m m
27. Is this an Emergency / a planned hospitalization:	28. Expected no. of days stay in Hospital:
29. Sum Total expected cost of Hospitalization	
30. Space for pasting the photo copy of the Health ID card of the Person hospitalized for treatment	Procedure where the ID Card is lost or misplaced or not with the patient

A Clear Copy of the Photo ID card of the Patient needs to be affixed here and is to be ATTESTED by the Hospital

If the Health ID card of LIC is not available, affix a copy of the latest passport size photograph of the person hospitalized or any other Photo ID proof (like a driver's license, voter's ID or PAN Card, Employee / Student ID)

We confirm having read, understood and agree to the declarations given below.

Treating doctors Signature
Name
Hospital Seal

Insured person's Signature
Name

Indemnity Form

I,_____s/o/d/o/w/o_____am the holder/beneficiary under policy No._____do hereby declare that the advance payment towards the applicable & eligible surgery under the above Health Insurance policy, is being made on the basis of the information given in the form of "**Request for Quick-Cash Facility under Major Surgical Benefits**" provided as a value added service under the policy.

In case it is found at the time of performance of Surgery or at the time of discharge from the hospital or at the point of claim evaluation that the Major Surgical Benefits are not payable or payable at a lesser benefit value for the hospitalization now claimed for, as per the policy Terms & Conditions, OR in case of any error in the Bank details given by me in the form of **"Request for Advance**" leading to a wrong payment & consequential loss to the Insurer, I shall immediately arrange to refund in full the advance amount paid, voluntarily and unconditionally.

I also declare that the decision of the hospital on the nature & type of surgery performed or the TPA's decision in processing the **"Request for advance"** or LIC's decision (based on their medical Panel's expert opinion resulting in rejection of the claim), shall be final and binding on me and there shall no be any dispute raised by me.

I also declare that in the event of my failure to refund the advance paid to me / my beneficiary in the above policy for any reason whatsoever, the advance so paid shall be treated as a load & liability on the said policy or other policies held by me with LIC and in the event of such non-repayment, the amount may be recovered through proper means as an arrears of revenue with interest.

Date:

Signature of the Insured
Name of the Insured:

A. HOSPITAL DECLARATION

1. We understand that this is NOT a Cashless Hospitalization and undertake to collect the full cost of treatment incurred by this patient before discharge from hospital as per our standard procedure for In-patients in this hospital
2. We have no objection to any authorized TPA/Insurance Company official verifying documents pertaining to hospitalization of the insured member in respect of whom the form is issued while still in hospital or after discharge.
3. All valid original documents as per the check list will be gives to the patient within 7 days of the patient's discharge.
4. The patient's ID has been verified & this document has been signed by the patient / representative in our presence.
5. We agree to provide clarifications for the queries raised by the TPA regarding this hospitalization and treatment

Hospital seal

Doctor's Signature.

Date:

Doctor's Name:

B. DECLARATION BY THE PATIENT /REPRESENTATIVE

1. I undertake to make the entire payment of Hospitalization Charges to the Hospital at the time of discharge2. I agree to submit all certified copies of the original documents pertaining to the hospitalization to the Insurer/TPA within 30 days from the date of discharge from the hospital.
3. In case the Insurer is not able to settle the Claim as per the terms and conditions of the policy in view of non-eligibility, I undertake to refund the Advance payment received from LIC in full.
4. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect, I forfeit my claim and agree to indemnify the Insurer.
5. I agree and understand that TPA/Insurer is in no way warranting the service of the hospital and that the Insurer/TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
6. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false statement, suppression or concealment, my right to claim the benefits under the policy shall be absolutely forfeited.
7. I declare, vouchsafe & certify that the Bank Account Number, IFSC Code, MICR Number, Name of the Bank furnished by me in the Request for Advance form are correct and for any wrong information resulting in any loss to the insurer, I will be solely responsible and liable.

Patient's /Insured's Name

Patient's/Insured's Signature

C. DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN ORIGINAL TO THE PATIENT AT DISCHARGE

1. Detailed Discharge Summary and all the prescriptions /bills from the hospital.
2. Summary of the Operation notes entered by the Surgeon in the OT Register and Patient's chart
3. Cash Memos from Hospitals/Chemists supported by proper prescriptions
4. Receipts and Pathological Test Reports from Pathologists, supported by advise from the attending Medical Practitioner/Surgeon recommending such pathological tests.
5. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.