

Sum Benefit:



**CLAIM FORM - PART A** TO BE FILLED IN BY THE INSURED (To be filled in block letter) The issue of this form is not to be taken as an admission of liability **DETAILS OF PRIMARY INSURED** a) Policy No: b) SI. No/certificate No: c) Company / TPA ID No SECTION A d) Name: e) Address : City: State: Pin Code: Phone No: Email ID **DETAILS OF INSURANCE HISTORY** a) Currently covered by any other Mediclaim / Health Insurance : ☐ Yes □ No SECTION B b) Date of commencement of first insurance without break: (copy of policies to be attached) c) If Company Name: Policy No: Sum Insured (Rs.): d) Have you been hospitalized in the last 4 year? Diagnosis: ☐ Yes ☐ No Date: e) Previously covered by any other Mediclaim / Health Insurance :  $\ \square$  Yes  $\ \square$  No  $\$ f) If Yes, Company Name : **DETAILS OF INSURED PERSON HOSPITALIZED** a) Name: ☐ Female Months d) Date of Brith b) Gender: 

Male c) Age : Year SECTION C e) Relationship to Primary Insured: 

Self □ Spouse ☐ Child □ Father ☐ Mother ☐ Other (Please specify) f) Occupation :  $\square$  Service  $\square$  Self Employed  $\square$  Homemaker (Please specify) ☐ Student □ Retired □ Other e) Address (if different from Above): City: State: Pin Code: Email ID: Phone No: **DETAIL OF HOSPITALIZATION** a) Name of Hospital where Admitted: SECTION D b) Room Category Occupied: 

Day Care  $\hfill \square$  Single Occupancy  $\ \square$  Twin Sharing  $\ \square$  3 Or more beds per room c) Hospitalization due to: 

Injury 

Illness □ Maternity d) Date of Injury / Date Disease First Detected / Date of Delivery : e) Date of Admission: g) Date Of Discharge: h) Time : f) Time: i) If Injury Give Cause: 

Self Inflicted ☐ Road TrafficAccident ☐ Substance / Alcohol Consumption i) If Medico legal: □ No ii) Reported To Police : ☐ Yes ☐ No iii) MLC Report & Police FIR Attached : 

Yes 

No 

j) System of Medicine : **DETAIL OF CLAIM** a) Details of The Treatment Expenses Claimed i. Pre-hospitalization Expenses: ii. Hospitalization Expenses: Rs. Rs. iii. Post-hospitalization Expenses: Rs iv. Health-Check up Cost: Rs. v. Ambulance charges: vi. Other (code): Rs. Rs Total Rs. SECTION E vii. Pre-hospitalisation period: days viii. Post-hospitalization Period : days b) Claim for Domiciliary Hospitalization : 

Yes  $\square$  No (If yes, provide details in annexure) c) Details Of Lump sum / Cash Benefit Claimed: i. Hospital Daily Cash: ii. Surgical Cash: Rs. Rs. ii. Critical Illness Benefit: iv. Convalescence: Rs. Rs. vi. Other: Rs. v. Pre/Post Hospitalization Lump

Total

	Claim Documents Submitted - Check List																	
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Date :	d d	n I	m	У	У			Place :		Signature of the insured								

## ANTI-MONEY LAUNDERING REQUIREMENT (For claim more than or equal to Rs. 1 Lakh - One Document each from (1) and (2))

- 1. Proposer's Identification (a) Passport (b) PAN Card (c) Voter's ID Card (d) Driving License (e) AADHAR Card
- 2. Proposer's Address (a) Current Telephone /Mobile Bill (b) Current Bank Passbook (c) Electricity Bill (d) Ration Card (e) Valid Rent Lease Agreement