

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) Sl. No/certificate No :

c) Company / TPA ID No :

d) Name : SURNAME FIRST NAME MIDDLE NAME

e) Address :

City : State :

Pin Code : Phone No : Email ID :

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Medclaim / Health Insurance : Yes No

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? Yes No Date : Diagnosis :

e) Previously covered by any other Medclaim / Health Insurance : Yes No f) If Yes, Company Name :

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name : SURNAME FIRST NAME MIDDLE NAME

b) Gender : Male Female c) Age : Year Months d) Date of Birth

e) Relationship to Primary Insured : Self Spouse Child Father Mother Other (Please specify)

f) Occupation : Service Self Employed Homemaker Student Retired Other (Please specify)

e) Address (if different from Above) :

City : State :

Pin Code : Phone No : Email ID :

DETAIL OF HOSPITALIZATION

a) Name of Hospital where Admitted :

b) Room Category Occupied : Day Care Single Occupancy Twin Sharing 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 : f) Time : g) Date Of Discharge : h) Time :

i) If Injury Give Cause : Self Inflicted Road Traffic Accident Substance / Alcohol Consumption i) If Medico legal : Yes 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 : Rs.	<input type="text"/>	ii. Hospitalization Expenses : Rs.	<input type="text"/>
iii. Post-hospitalization Expenses : Rs.	<input type="text"/>	iv. Health-Check up Cost : Rs.	<input type="text"/>
v. Ambulance charges : Rs.	<input type="text"/>	vi. Other (code) : <input type="text"/>	Rs. <input type="text"/>
		Total	Rs. <input type="text"/>
vii. Pre-hospitalisation period : days	<input type="text"/>	viii. Post-hospitalization Period : days	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

b) Claim for Domiciliary Hospitalization : Yes No (If yes, provide details in annexure)

c) Details Of Lump sum / Cash Benefit Claimed:

i. Hospital Daily Cash : Rs.	<input type="text"/>	ii. Surgical Cash : Rs.	<input type="text"/>
ii. Critical Illness Benefit : Rs.	<input type="text"/>	iv. Convalescence : Rs.	<input type="text"/>
v. Pre/Post Hospitalization Lump Sum Benefit : Rs.	<input type="text"/>	vi. Other : Rs.	<input type="text"/>
		Total	Rs. <input type="text"/>

Claim Documents Submitted - Check List

- | | |
|--------------------------------------------------------|-------------------------------------------------------------------------------|
| <input type="checkbox"/> Claim Form Duly Signed | <input type="checkbox"/> Operation Theater Notes |
| <input type="checkbox"/> Copy of the claim Intimation | <input type="checkbox"/> ECG |
| <input type="checkbox"/> Hospital Main Bill | <input type="checkbox"/> Doctor's Request For Investigation |
| <input type="checkbox"/> Hospital Break-up Bill | <input type="checkbox"/> Investigation Report (Including CT / MRI/ USG / HPE) |
| <input type="checkbox"/> Hospital Bill Payment Receipt | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hospital Discharge Summary | |
| <input type="checkbox"/> Pharmacy Bill | |

DETAILS OF BILL ENCLOSED

Sl. No	Bill No	Date	Issued by	Towards	Amount (RS)
1.		d d m m y y		Hospital Main Bill	
2.		d d m m y y		Pre-hospitalization: _____Nos	
3.		d d m m y y		Pre-hospitalization: _____Nos	
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			

DETAILS PRIMARY INSURED'S ACCOUNT

a) Pan : b) Account Number :

c) Bank Name and Branch :

d) Cheque/ DD Payable details : e) IFSC Code :

DECLARATION BY THE INSURED

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, 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 :

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))

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