CLAIM FORM - PART A' to 'CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED BY THE INSURED The issue of this form is not to be taken as an admission of liability (To be Filled in block letters) DETAILS OF PRIMARY INSURED: c) Company! TPA IO No: SURNAVE FIRST MAME MEDULE NAME City: Pin Code Phone No: Email ID: DETAILS OF INSURANCE HISTORY: a) Currently covered by any other Mediclaim / Health Insurance: Yes No b) Date of commencement of first insurance without break: D 3 M YYYY c) If yes, company name: Date: [# 우 Y Y Diagnosis: e) Previously covered by any other Mediclaim /Health insurance :: Yes No 1) If yes, company name: DETAILS OF INSURED PERSON HOSPITALIZED: SURNAME MIDDLE NAME c) Age years Y Y Months M M d) Date of Birth D D M M b) Gender Male Female YYYY Spouse Child Father Mother Other (Please Specify) a) Relationship to Primary insured: f) Occupation Service Setf Employed Home Maker Student Retired Other (Please Specify) g) Address (if diffrent from above): Phone No: Email ID: Pin Code | | | | | | | | DETAILS OF HOSPITALIZATION: : a) Name of Hospital where Admited: Day care b) Room Category occupied: Single occupancy [7] Twin sharing 3 or more beds par room injury 🔲 Illness 🚺 c) Hospitalization due to: Malemity [d) Date of injury / Date Disease first detected /Date of Delivery: MAYYYY e) Date of Admission: D D M H YY f) Time [H] [H] g) Date of Discharge: D D M M Y Y h) Time: B H : M B Self inflicted 🔲 Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes No (i) Reported to Police П ili. MLC Report & Police FIR attached Yes No]) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed Claim Documents Submitted - Check List: I. Pre -hospitalization expenses Rs. ii. Hospitalization expenses Claim form duty signed Copy of the claim intimation, if any iv. Health-Check up cost: ili. Post-hospitalization expenses Hospital Main Bill v. Ambulance Charges: Rs. [] [] [] [] [] [] vi. Others (code); Rs. Hospital Break-up Bill Hospital Bill Payment Receipt days 🔲 🔲 💮 vfi. Pre -hospitalization period: viti. Post -hospitalization period: days Hospital Discharge Summery Yes No (If yes, provide details in annexure) b) Claim for Domicklery Hospitalization; Pharmacy Bill c) Details of Lump sum / cash benefit claimed: Operation Theater Notes Rs. ☐ ECG i. Hospital Daily cash: li. Suroicaí Cash: Doctor's request for investigation iii. Critical Ainess benefit: iv. Convalescence Investigation Reports (Including CT / MRI / USG / HPE) П v. Pre/Post hospitalization Lump sum benefit: Rs. vi. Others: Rs. Doctor's Prescriptions ☐ Others DETAILS OF BILLS ENCLOSED: St. No. Bill No. Date Issued by Towards Amount (Rs) D M M Y Y Hospital main Bill D D M. M Pre-hospitalization Bills: Nos 3. # # Y Y Ď. D. Post-hospitalization Riller Nos 4. ם מ M M Y Pharmacy Billis 5. M M Y Y D Ð 6. 植植 ¥ Y 7. Ď M 34 ¥ MMYY 8. D I Ð M. MY D ٥ DDMMAY DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

b) Account Number:

e) IFSC Code:

c) Bank Name and Branch:

d) Cheque / DO Payable details:

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I hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealent of any material fact with respect to questions asked in relation to this claim, my right to claim reimbrusement shall be forfeited, I also consent & authorize TPA I insurance Company, to seek necessary medical information I documents from any hospital I Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bits I receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

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Date 0 D M M	Y Y Y Place:	Signature of the Insured	

		CE FOR FILLING CLAIM FORM - PART A (To be filled in by the in	
\vdash	DATA ELEMENT	DESCRIPTION	FORMAT
\vdash		SECTION A - DETAILS OF PRIMARY INSURED	
a	·	Enter the policy number Enter the social insurance number or the certificate number	As alloited by the Insurance Company
Ь) St. No/ Certificate No.	social health insurance scheme	As abouted by the oraganization
c)	Company TPA iD No.	Enter the TPA ID No.	Licence number as allotted by IRDA and In TPA documents.
d)	Name	Enter the full name of the policyholder	Surname, First name, Middle name
8)	Address	Enter the full postal address	Include Street, City and Pin code
Ļ		SECTION B -DETAILS OF INSURANCE HISTORY	
a)	Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b)	Date of commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy-format
c)	Company Name	Enter the full name of the Insurance Company	Name of the organization in full
	Policy No.	Enter the policy reumber	As alfotted by the Insurance Company
	Sum insured	Enter the total sum insured as per the policy	in rupees
d)	Have you been Hospitalized in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
	Date	Enter the date of Hospitalization	Use mm-yy format
	Diagnosis	Enter the diagnosis details	Open Text
e)	Previously covered by any other Mediciaim / Health	Indicate whether previously covered by another mediciaim /	Tick Yes or No
	Insurance?	Health (neurence	
ŋ	Company Náme	Enter the full name of the Insurance Company	Name of the organization in full 1
<u>.</u>		CTION C DETAILS OF INSURED PERSON HOSPITALIZED	<u> </u>
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
1)	Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy formal
;}	Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option, if others, please specify
_	Occupation	indicate occupation of patient	Tick the right option. If others, please specify
)	Address	Enter the full postal address	Include Street, City and Pin code
)	Phone No	Enter the phone number of patient	Include STD code with telephone number
)	E-mail ID	Enter e-mail address of patient	Complete e-mail address
	**************************************	SECTION D - DETAILS OF HOSPITALIZATION	
<u> </u>	Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
<u> </u>	Room category occupied	Indicate the room category occupied	Tick the right option
	Hospitalization due to	indicate reason of hospitalization	Tick the right option
	Date of injury/Date Disease first detected / Date of Defivery	Enter the relevant date	Use dd-mm-yy format
	Date of admission	Enter date of admission	Use dd-mm-yy format
7	Time :	Enter time of admission	Use hh-mm- format
-	Date of discharge	Enter date of discharge	Use dd-mm-yy format
_	Time .	Enter time of discharge	Use hh-mm- format
lt.	finjury give cause	indicate cause of injury	Tick the right option
I#	Medico (egal	indicate whether injury is medico legal	Tick Yes or No
R	Reported to Police	indicate whether police report was filed	Tick Yes or No
M	ILC Report & Police FtR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
S	ystem of Medicene	Enter the system of medicine followed in treating the patient	Open Text
_		SECTION E - DETAILS OF CLAIM	
Ö	Details of Treatment Expences	Enter the amount claimed as treatment expences	In rupees (Do not enter palse values)
C	Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
D	etalls of Lump sum/ Cash benifit claimed	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
C	Salm documents Submitted-Check List	indicate which supporting documents are submitted	Tick the right option
		SECTION F - DETAILS OF BILLS ENCLOSED	
ate	which bills are enclosed with the amount in rupees	· · · · · · · · · · · · · · · · · · ·	
		G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	
PA	AN T	Enter the permanent account number	As allotted by the Income Tax Department
Ac	count Number	Enter the Bank account number	As allotted by the Bank
	ank Name and Branch	Enter the Bank name along with the branch	Name of the Bank in full
		Enter the name of the beneficiary the cheque / DD should be	
			Name of the individual / organization in full
Ch		made out to Enter the (FSC code of the Bank branch	IFSC code of the Bank branch in full