CLAIM FORM – PART A TO BE FILLED IN 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:	
a) Policy No:	b) Sl. No/ Certificate No:
d) Name : SURNAME FI	
e) Address :	
City:	State:
Pin Code: Phone No: Phone	Email ID :
DETAILS OF INSURANCE HISTORY:	
	of commencement of first Insurance without break: DDD MMM YYY (Copies of Policies to be attached)
c) If yes, company name:	Policy No.
Sum Insured (Rs.) d) Have you been hospitalized in the last	
e) Previously covered by any other Mediclaim / Health insurance : Yes No DETAILS OF INSURED PERSON HOSPITALIZED:	f) If yes, Company Name
a) Name: SURNAME FI	
b) Gender: Male Female c) Age: years Y Y months	
f) Occupation: Service Self Employed Homemaker Student	Retired Other (Please Specify)
g) Address (if different from above):	
City:	
Pin Code: Phone No: Phone Phon	E-mail ID:
DETAILS OF HOSPITALIZATION:	
a) Name of Hospital where Admitted:	
b) Room Category occupied: Day care Single occupancy	Twin sharing 3 or more beds per room
	d) Date of Injury / Date Disease first detected /Date of Delivery:
e) Date of Admission: DDD MMM YYY f) Time: HH HH:	M M g) Date of Discharge: D D M M Y Y h) Time: H H : M M
i) If Injury give cause: Self inflicted Road Traffic Accident	Substance Abuse / Alcohol Consumption i. If Medico legal: Yes No
	Yes No j) System of Medicine:
DETAILS OF CLAIM:	Yes No j) System of Medicine:
DETAILS OF CLAIM: a) Details of the treatment expenses claimed	Claim Documents Submitted- Check List:
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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.

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Date: D D M M	Y Y Place:	Signature of the Insured	ON H

	DATA ELEMENT	DESCRIPTION	FORMAT
		SECTION A - DETAILS OF PRIMARY INSURED	L
1)	Policy No.	Enter the policy number	As allotted by the insurance company
)	SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
)	Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
)	Name	Enter the full name of the policyholder	Surname, First name, Middle name
)	Address	Enter the full postal address	Include Street, City and Pin Code
		SECTION B - DETAILS OF INSURANCE HISTORY	
)	Currently covered by any other Mediclaim / Health	Indicate whether currently covered by another Mediclaim /	Tick Yes or No
_	Insurance?	Health Insurance	
)	Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
)	Company Name	Enter the full name of the insurance company	Name of the organization in full
	Policy No.	Enter the policy number	As allotted by the insurance company .
_	Sum Insured	Enter the total sum insured as per the policy	In rupees
)	Have you been Hospitalized in the last 4 years	Indicate whether hospitalized in the last 4 years	Tick Yes or No
	Date	Enter the date of hospitalization	Use mm-yy format
)	Diagnosis	Enter the diagnosis details	Open Text
	Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
	Company Name	Enter the full name of the insurance company	Name of the organization in full
	SECTIO	ON C - DETAILS OF INSURED PERSON HOSPITALIZED	,
	Name	Enter the full name of the patient	Surname, First name, Middle name
,	Gender	Indicate Gender of the patient	Tick Male or Female
)	Age	Enter age of the patient	Number of years and months
)	Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
)	Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please spec
_	Occupation	Indicate occupation of patient	Tick the right option. If others, please speci
)	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	Complete o mail addition
)	Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
i)	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	·	
_	Delivery	Enter the relevant date	Use dd-mm-yy format
)	Date of admission	Enter date of admission	Use dd-mm-yy format
	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
	If Injury give cause	Indicate cause of injury	Tick the right option
	If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
	Reported to Police	Indicate whether police report was filed	Tick Yes or No
	MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
	System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
		SECTION E - DETAILS OF CLAIM	
)	Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
)	Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
)	Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
)	Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
_		SECTION F - DETAILS OF BILLS ENCLOSED	
di	cate which bills are enclosed with the amounts in rupees	C. DETAILS OF DDIMARY INCUDENCE DAME ACCOUNT	
_		G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	As allotted by the learning T. I
)	PAN	Enter the permanent account number	As allotted by the Income Tax department
)	Account Number	Enter the bank account number	As allotted by the bank
:)	Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
)	Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization in full
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Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.