CLAIM FORM - PART A

(To be Filled in block letters)

TO BE FILLED BY THE INSURED The issue of this Form is not to be taken as an admission of liablity

DETAILS OF PRIMARY INSURED:									
a) Policy No.: D D D D D D D D D D D D D D D D D D D									
	E			ר					
				ן קר					
a) Currently covered by any other Mediclaim / Health Insurance: Yes No b) Date of commencement of first Insurance without break: DD MMM	YY	ΥY							
				ñ					
c) If yes, company name:									
Diagnosis: e) Previously covered by any other Mediclaim /Health insurance :: Yes No f) If yes, company name: Image: Compa									
DETAILS OF INSURED PERSON HOSPITALIZED: :									
				-					
		IAME							
				_ ٦					
f) Occupation Service Self Employed Home Maker Student Other (Please Specify)		7 1 1							
				- 1					
Pin Code Phone No: Email ID:				-					
DETAILS OF HOSPITALIZATION: :				_					
a) Name of Hospital where Admited:									
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: D	M	ΥY	ΥY	G					
e) Date of Admission: D D M M Y Y f) Time H H M H g) Date of Discharge: D D M M Y Y	e) Date of Admission: DD MMM YY f) Time HHH MH g) Date of Discharge: DD MM YY h) Time: HHH : MHH								
I) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes No									
I) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal] Yes 🗌 I			1					
I) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine:] Yes [] I								
] Yes []								
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: P) Patrile of the Tractment support a laired			Check List:						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: P) Patrile of the Tractment support a laired	n Document	No	Check List:						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine:	n Document Claim form Copy of the	s Submitted - (duly signed e claim intimatio							
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine:	n Document Claim form Copy of the Hospital M	s Submitted - (duly signed e claim intimatio ain Bill							
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine:	n Document Claim form Copy of the Hospital M Hospital Bi	s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill	n, if any						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine:	n Document Claim form Copy of the Hospital M Hospital Bi Hospital Bi	s Submitted - 0 duly signed e claim intimatio ain Bill eak-up Bill Il Payment Reco	n, if any eipt						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine:	n Document Claim form Copy of the Hospital M Hospital Bi Hospital Bi	s Submitted - 0 duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ	n, if any eipt						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs. Iii. Hospitalization expenses Rs. iii. Post-hospitalization expenses Rs. Iii. Hospitalization expenses Rs. Iii. Hospitalization expenses Iii. Hospitalization expenses v. Ambulance Charges: Rs. Iii. Intersection expenses Iii. Intersection expense Iii. Intersection expenses Iii. Intersection expenses vi. Pre -hospitalization period: days Iiii. Intersection period: Iiii. Post -hospitalization period: Iiii. Intersection period: Iiiii. Intersection period: Iiiiii. Intersection period: IIiiii. IIiiiii.<	n Document Claim form Copy of the Hospital Bi Hospital Di Hospital Di Pharmacy	s Submitted - 0 duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ	n, if any eipt						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed Claim I. Pre -hospitalization expenses Rs. Iii. Hospitalization expenses Rs. iii. Post-hospitalization expenses Rs. Iii. Hospitalization expenses Rs. v. Ambulance Charges: Rs. Iii. In the spitalization expense is a standard in the spitalization period: Interval is a standard in the spitalization expense is a standard in the spitalization expense is a standard in the spitalization expense is a standard in the spitalization in the spitalization is a standard in the spitalization in the spitalization expense is a standard in the spital expense is a standard in the spitalizat	n Document Claim form Copy of the Hospital Bi Hospital Di Hospital Di Pharmacy	s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Reco scharge Summ: Bill	n, if any eipt						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed Claim a) Details of the Treatment expenses Rs. ii. Hospitalization expenses Rs. iii. Post-hospitalization expenses Rs. iii. Hospitalization expenses Rs. v. Ambulance Charges: Rs. iv. Health-Check up cost: Rs. vii. Pre -hospitalization period: days iv. vii. Pre -hospitalization period: days iv. b) Claim for Domiciliary Hospitalization: Yes No (If yes, provide details in annexure) c) Details of Lump sum / cash benefit claimed:	n Document Claim form Copy of the Hospital Bi Hospital Di Pharmacy Operation ECG Doctor's re	s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Reco scharge Summ: Bill Theater Notes quest for invest	n, if any eipt ary						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed Image: Claim of the treatment expenses claimed Claim of the treatment expenses claimed Claim of the spitalization expenses Rs. Image: Claim of the spitalization Image: Claim of the spitalization expenses Rs. Image: Claim of the spitalization Image: Claim	n Document Claim form Copy of the Hospital M Hospital Bi Hospital Di Pharmacy Operation ECG Doctor's re Investigatic / MR1 / US	s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ Bill Theater Notes quest for invests un Reports (Incl) 3 / HPE)	n, if any eipt ary						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed Claim ii. Pre -hospitalization expenses Rs. Iii. Hospitalization expenses Rs. iii. Post-hospitalization expenses Rs. Iii. Hospitalization expenses Rs. v. Ambulance Charges: Rs. Iii. Post-hospitalization period: days Iii. Post-hospitalization period: days vii. Pre -hospitalization period: days Iii. Post-hospitalization period: days Iii. Post-hospitalization period: days o) Details of Lump sum / cash benefit claimed: Iii. Surgical Cash: Rs. Iii. Surgical Cash: Rs. II. Hospital Daily cash: Rs. Iii. Surgical Cash: Rs. Iii. Surgical Cash: Rs.	n Document Claim form Copy of the Hospital M Hospital Di Hospital Di Pharmacy Operation ECG Doctor's re Investigation MRI / US Doctor's P	s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ Bill Theater Notes quest for invests un Reports (Incl) 3 / HPE)	n, if any eipt ary						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No i) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs. Hospitalization expenses Rs.	n Document Claim form Copy of the Hospital M Hospital Bi Hospital Di Pharmacy Operation ECG Doctor's re Investigatic / MR1 / US	s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ Bill Theater Notes quest for invests un Reports (Incl) 3 / HPE)	n, if any eipt ary						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs. Hospitalization expenses Rs. Hospitalization expenses Rs. Hospitalization expenses Rs.	n Document Claim form Copy of the Hospital M Hospital Di Hospital Di Pharmacy Operation ECG Doctor's re Investigation MRI / US Doctor's P	s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ Bill Theater Notes quest for invests un Reports (Incl) 3 / HPE)	n, if any eipt ary igation uding CT						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs. Hospitalization expenses Rs.	n Document Claim form Copy of the Hospital M Hospital Di Hospital Di Pharmacy Operation ECG Doctor's re Investigation MRI / US Doctor's P	s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ: Bill Theater Notes quest for invest on Reports (Incl G / HPE) escriptions	n, if any eipt ary igation uding CT						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed Claim 1. Pre -hospitalization expenses Rs	n Document Claim form Copy of the Hospital M Hospital Di Hospital Di Pharmacy Operation ECG Doctor's re Investigation MRI / US Doctor's P	s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ: Bill Theater Notes quest for invest on Reports (Incl G / HPE) escriptions	n, if any eipt ary igation uding CT						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs. II. Hospitalization expenses Rs. iii. Post-hospitalization expenses Rs. III. Hospitalization expenses Rs. vi. Pre -hospitalization period: days III. Pre -hospitalization period: days vii. Pre -hospitalization period: days III. Pre -hospitalization period: days vii. Pre -hospitalization period: days III. Pre -hospitalization period: days vii. Pre -hospitalization Yes No (If yes, provide details in annexure) o) Details of Lump sum / cash benefit claimed: III. Surgical Cash: Rs. III. Critical Illness benefit: Rs. III. Surgical Cash: Rs. Vi. Others: Rs. III. Critical Illness benefit: Rs. Vi. Others: Rs. III. Critical Illness benefit: Rs. Vi. Others: Rs. III. Critical Illness benefit: Rs. Vi. Others: Rs. IIII. Critical Illness Rs. De D M M Y Y Hospital main Bill III. 2. D D M M Y Y Pre-hospitalization Bills: 3. D D M M Y Y Pre-hospitalization Bills: Nos 3. D D M M Y Y Phost-hospitalization Bills: Nos	n Document Claim form Copy of the Hospital M Hospital Di Hospital Di Pharmacy Operation ECG Doctor's re Investigation MRI / US Doctor's P	s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ: Bill Theater Notes quest for invest on Reports (Incl G / HPE) escriptions	n, if any eipt ary igation uding CT						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed Claim 1. Pre -hospitalization expenses Rs	n Document Claim form Copy of the Hospital M Hospital Di Hospital Di Pharmacy Operation ECG Doctor's re Investigation MRI / US Doctor's P	s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ: Bill Theater Notes quest for invest on Reports (Incl G / HPE) escriptions	n, if any eipt ary igation uding CT						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs. I. Pre -hospitalization expenses Rs. I. Pre -hospitalization expenses Rs. I. Pre -hospitalization period: days VIII. Pre -hospitalization period: Rs. Surgical Cash: Rs. Rs. Claim for Domiciliary Hospital main bill Claim for Domiciliary Hospital main Bill Clai Rs. Clai Rs. Clai Rs. Claim Rs. Claim Rs. Claim Rs. Claim Rs. Claim Rs. Claim Rs. <l< td=""><td>n Document Claim form Copy of the Hospital M Hospital Di Hospital Di Pharmacy Operation ECG Doctor's re Investigation MRI / US Doctor's P</td><td>s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ: Bill Theater Notes quest for invest on Reports (Incl G / HPE) escriptions</td><td>n, if any eipt ary igation uding CT</td><td></td></l<>	n Document Claim form Copy of the Hospital M Hospital Di Hospital Di Pharmacy Operation ECG Doctor's re Investigation MRI / US Doctor's P	s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ: Bill Theater Notes quest for invest on Reports (Incl G / HPE) escriptions	n, if any eipt ary igation uding CT						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed Claim 1. Pre-hospitalization expenses Rs. III. Hospitalization expenses Rs. iii. Post-hospitalization expenses Rs. III. Hospitalization expenses Rs. iii. Post-hospitalization expenses Rs. III. Hospitalization expenses Rs. iii. Post-hospitalization expenses Rs. III. Hospitalization expenses Rs. vii. Pre-hospitalization period: days III. Post-hospitalization period: days viii. Pre-hospitalization period: days III. Post-hospitalization period: days viii. Pre-hospitalization period: days III. Post-hospitalization period: days viii. Pre-hospitalization period: days III. Surgical Cash: Rs. iii. Guint for Domiciliary Hospitalization: Yes No (If yes, provide details in annexure) c) Details of Lump sum / cash benefit: Rs. III. Surgical Cash: Rs. III. Chricat Illness benefit: Rs. III. Surgical Cash: Rs. V. Pre/Post hospitalization Lump sum benefit: Rs. VIII. Port-hospitalization Billis: Nos Si. No Bill No. D D M M Y Y Pre-hospitalization Billis: Nos 3. D D D M M Y Y Pre-hospitalization Billis: Nos 3. D D M M Y Y Pharmacy Billis Nos 3. D D M M Y Y Ph	n Document Claim form Copy of the Hospital M Hospital Di Hospital Di Pharmacy Operation ECG Doctor's re Investigation / MRI / US/ Doctor's P	s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ: Bill Theater Notes quest for invest on Reports (Incl G / HPE) escriptions	n, if any eipt ary igation uding CT						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs. I. Pre -hospitalization expenses Rs. I. Pre -hospitalization expenses Rs. I. Pre -hospitalization period: days VIII. Pre -hospitalization period: Rs. Surgical Cash: Rs. Rs. Claim for Domiciliary Hospital main bill Claim for Domiciliary Hospital main Bill Clai Rs. Clai Rs. Clai Rs. Claim Rs. Claim Rs. Claim Rs. Claim Rs. Claim Rs. Claim Rs. <l< td=""><td>n Document Claim form Copy of the Hospital M Hospital Di Hospital Di Pharmacy Operation ECG Doctor's re Investigation / MRI / US/ Doctor's P</td><td>s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ: Bill Theater Notes quest for invest on Reports (Incl G / HPE) escriptions</td><td>n, if any eipt ary igation uding CT</td><td></td></l<>	n Document Claim form Copy of the Hospital M Hospital Di Hospital Di Pharmacy Operation ECG Doctor's re Investigation / MRI / US/ Doctor's P	s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ: Bill Theater Notes quest for invest on Reports (Incl G / HPE) escriptions	n, if any eipt ary igation uding CT						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No)) System of Medicine: DETAILS OF CLAME: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs. Hospitalization expenses Rs. Pre-hospitalization expenses Rs. Pre-hospitalization expenses Rs. Pre-hospitalization expenses Rs. Pre-hospitalization expenses Rs. Pre-hospitalization expenses Rs.	n Document Claim form Copy of the Hospital M Hospital Di Hospital Di Pharmacy Operation ECG Doctor's re Investigation / MRI / US/ Doctor's P	s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ: Bill Theater Notes quest for invest on Reports (Incl G / HPE) escriptions	n, if any eipt ary igation uding CT						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre-hospitalization expenses Rs. Iii. Hospitalization expenses Rs. Iii. Post-hospitalization expenses Rs. Iii. Hospitalization expenses Rs. III. Post-hospitalization expenses Rs. III. Post-hospitalization expenses Rs. III. Post-hospitalization expenses Rs. III. Post-hospitalization period: days V. Ambulance Charges: Rs. III. Post-hospitalization period: days Vii. Pre-hospitalization period: days III. Post-hospitalization period: days Vii. Pre-hospitalization Yes No (If yes, provide details in annexure) c) Details of Lump sum / cash benefit claimed: III. Surgical Cash: Rs. III. Hospitalization Lump sum benefit: Rs. III. Surgical Cash: Rs. III. Chitcal Illness benefit: Rs. III. Convalescence: Rs. V. Pre/Post hospitalization Lump sum benefit: Rs. Vi. Others: Rs. III. D D M M Y Y Hospital main Bill 2. D D M M Y Y Post-hospitalization Bills: S. D D M M Y Y Pharmacy Bills S. D D M M Y Y Pharmacy Bills S. D D M M Y Y Pharmacy Bills S. D D M M Y Y Pharmacy Bills S. D D M M Y Y III. S. D D M M Y Y III. </td <td>n Document Claim form Copy of the Hospital M Hospital Di Hospital Di Pharmacy Operation ECG Doctor's re Investigation / MRI / US/ Doctor's P</td> <td>s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ: Bill Theater Notes quest for invest on Reports (Incl G / HPE) escriptions</td> <td>n, if any eipt ary igation uding CT</td> <td></td>	n Document Claim form Copy of the Hospital M Hospital Di Hospital Di Pharmacy Operation ECG Doctor's re Investigation / MRI / US/ Doctor's P	s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ: Bill Theater Notes quest for invest on Reports (Incl G / HPE) escriptions	n, if any eipt ary igation uding CT						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed Claim I. Pre -hospitalization expenses Rs. Hospitalization expenses Rs.	n Document Claim form Copy of the Hospital M Hospital Di Hospital Di Pharmacy Operation ECG Doctor's re Investigation / MRI / US/ Doctor's P	s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ: Bill Theater Notes quest for invest on Reports (Incl G / HPE) escriptions	n, if any eipt ary igation uding CT						
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No i) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed If Pre -hospitalization expenses Rs. If Health-Check up cost: Rs. If Chail Rs. If Pre -hospitalization period: days V. Health-Check up cost: Rs. If Chail Rs. If Chical Illness benefit: Rs. If Surgical Cash: Rs. If Chical Illness benefit: Rs. Rs and the protexplatigization Bills:<	n Document Claim form Copy of the Hospital M Hospital Di Hospital Di Pharmacy Operation ECG Doctor's re Investigation / MRI / US/ Doctor's P	s Submitted - (duly signed e claim intimatio ain Bill eak-up Bill Il Payment Recc scharge Summ: Bill Theater Notes quest for invest on Reports (Incl G / HPE) escriptions	n, if any eipt ary igation uding CT						

DECLARATION BY THE INSURED:

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 / 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.

SECTION H

Date	DD	MM	YYYY	Place:

Signature of the Insured

	DATA ELEMENT	DESCRIPTION	FORMAT
	1	SECTION A - DETAILS OF PRIMARY INSURED	
a)	Policy No.	Enter the policy number	As allotted by the Insurance Company
b)	SI. No/ Certificate No.	Enter the social Insurance number or the certificate number of	As allotted by the oraganization
		social health insurance scheme	Licence number as allotted by IRDA and printe
c)	Company TPA ID No.	Enter the TPA ID No.	in TPA documents.
d)	Name	Enter the full name of the policyholder	Surname, First name, Middle name
e)	Address	Enter the full postal address	Include Street, City and Pin code
a)	Currently covered by any other Mediclaim / Health	SECTION B -DETAILS OF INSURANCE HISTORY Indicate whether currently covered by another Mediclaim /	1
.,	Insurance?	Health Insurance	Tick Yes or No
))	Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yy-forrmat
:)	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
4)	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
	Previously covered by any other Mediclaim / Health	Indicate whether previously covered by another mediclaim /	Tick Yes or No
	Insurance? Company Name	Health Insurance Enter the full name of the Insurance Company	Name of the organization in full
)		ION C -DETAILS OF INSURED PERSON HOSPITALIZED	Name of the organization in full
			Sumana First same Middle same
1)	Name Gender	Enter the full name of the patient Indicate Gender of the patient	Surname, First name, Middle name Tick Male or Female
))			
))	Age Date of Birth	Enter age of the patient	Number of years and months
<i>,</i>		Enter Date of Birth of patient	Use dd-mm-yy format
e)	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
1)	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	1
a)	Name of Hospital where admited	Enter the name of hospital	Name of hospital in full
)	Room category occupied	indicate the room category occupied	Tick the right option
;)	Hospitalization due to	indicate reason of hospitalization	Tick the right option
1)	Date of injury/Date Disease first detected / Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e)	Date of admission	Enter date of admission	Use dd-mm-yy format
)	Time	Enter time of admission	Use hh-mm- format
1)	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 Medicene	Enter the system of medicine followed in treating the patient	Open Text
		SECTION E - DETAILS OF CLAIM	1
ı)	Details of Treatment Expences	Enter the amount claimed as treatment expences	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 benifit 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	,
ndic	ate which bills are enclosed with the amount in rupees		
		N G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	
)	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
<i>'</i>)		Enter the name of the beneficiary the cheque / DD should be	Name of the individual / organization in full
-	Cheque/DD navable details		
;) ;)	Cheque/ DD payable details IFSC Code	made out to Enter the IFSC code of the Bank branch	IFSC code of the Bank branch in full