REIMBURSEMENT CLAIM FORM

TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability

DETAILS OF PRIMARY INSURED

a) Policy No: 12030034200400000010	b)Sl.No/Certificate No:
c) Company/TPA ID No: Nokia	
d) Name : Ajmal Hussain	
e) Address : H.no 28 Sathiyavani Muthu street, Vill-Highway road, Sholinganallur Chennai 600119	City: Chennai
State: Tamil Nadu	Pin Code: 600119
Phone No: 9650462862	Email ID : AJMAL.HUSSAIN@NOKIA.COM

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim/Health Insurance: -	b) Date of commencement of first Insurance without break:
c) If yes,company name:	Policy No:
Sum Insured (Rs.) :	d) Have you been hospitalized in the last four years since inception of the contract? : -
e) Previously covered by any other Mediclaim/Health insurance : -	f) If yes,Company Name:

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Select Member: Taslimuddin	B) Gender: Male
C) Age: 59	D) Date of Birth: 01 Jan 1962
e) Relationship to Primary insured: Father	
f) Occupation: Self Employed	
g) Address (if different from above): Loharpatti road, Nawabganj, Kishanganj, Bihar	City: Kishanganj
State: Bihar	Pin Code: 855108
Phone No: 9650462862	Email ID : ajmal.hussain@nokia.com

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted: Novs Clinic	
b) Room Category occupied: Day care	
c) Hospitalization due to: Injury	d) Date of Injury/Date Disease first detected/Date of Delivery: 15 Apr 2021
e) Date of Admission: 15 Apr 2021	f) Time:
g) Date of Discharge: 30 Aug 2021	h) Time:
i) If Injury give cause: Road Traffic Accident	i.If Medico legal: No
ii.Reported to police: No	iii.MLC Report & Police FIR attached: No
j) System of Medicine: Leg broken plaster	

DETAILS OF CLAIM:

a) Details of the treatment expenses claimed i.Pre-hospitalization Expenses:	i.Hospitalization Expenses: 6600
iii.Post-hospitalization Expenses:	iv.Health-Check up Cost:900
v.Ambulance Charges:	vi.Others (code): Amount:
	Total: 7500
vii.Pre-hospitalization period:Days	viii.Post-hospitalization period:Days
b)Claim for Domiciliary Hospitalization: -	
c) Details of Lump sum/cash benefit claimed: i.Hospital Daily Cash:	ii.Surgical Cash:
iii.Critical Illness Benefit:	iv.Convalescence:
v.Pre/Post hospitalization Lump sum benefit:	vi.Others: Amount:
	Total:
Claim Documents Submitted- Check List: Claim Form Duly signed,Hospital Break-up Bill,Investigation Reports(Including CT/MRI/USG/HPE),Doctor's Prescriptions	

DETAILS OF BILLS ENCLOSED:

Sl.No	Bill No	Date	Issued by	Towards	Amount(Rs)
1	Consultation fee	15 Apr 2021			500
2	First Plaster fee	18 Jun 2021			3200
3	xray	18 Jun 2021			400
4	Second Plaster fee	03 Aug 2021			3400
5					
6					
7					
8					
9					
10					

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a)PAN:AFEPH1044Q	b)Account Number:914010046426999
c)Bank Name and Branch:Axis Bank Tolichowki Branch	
d) Cheque/DD Payable details:	e) IFSC Code:UTIB0001628

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.

This claim form is computer generated, created with secure login hence no signature is required.

Date:11 Oct 2021	Place:Chennai	Signature of the Insured/Name:Ajmal Hussain