

"Claim with Bajaj Allianz
General Insurance
Co Ltd"



(To be filled in block letters)

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A

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: 0 G - 2 5 - 1 9 1 9 - 8 4 0 3 - 0 0 0 0 0 2 0 8 b) Sl. No/Certificate No:
c) Company TPA ID No:
d) Customer ID:
e) Company Name: DELOITTE CONSULTING INDIA PRIVATE LIMITED f) Employee No: 703063
g) Name: P R A J J W A L T A W R I
h) Address: H - 2 1 1 . P A T A N J A L I S H O P G A N J P A R A S A T T I C H
O U R A N E A R H A N U M A N M A N D I R
City: D U R G State: C H A T T I S G A R Pin Code: 4 9 1 0 0 1
Phone No: 8 3 4 9 0 8 2 0 2 8 Email ID: PTAWRI@DELOITTE.COM

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediciam / Health Insurance ☐ Yes ☒ No
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? ☐ Yes ☒ No Date: D D M M Y Y Y Y
Diagnosis
e) Previously covered by any other Mediciam / Health Insurance: ☐ Yes ☒ No
f) If yes, Company Name

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name of the Patient: PRAJWAL TAWRI
b) Health ID card no of the Patient: DCI-25-50666977
c) Gender: Male ☒ Female ☐ d) Age: years 2 4 months 0 5 e) Date of Birth D D M M Y Y Y Y
f) Relationship of Primary insured: Self ☒ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ (Please Specify)
g) Occupation: Service ☒ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ (Please Specify)
h) Address (if different from above)
City: State: Pin Code:
i) Phone No: 8 3 4 9 0 8 2 0 2 8 j) Email ID: PTAWRI@DELOITTE.COM

DETAILS OF HOSPITALIZATION

a) Name of Hospital where Admitted: VAYAM HOSPITAL(VAYAM HEALTH CARE)
b) Room Category occupied: Day Care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐
c) Hospitalisation due to: Injury ☒ Illness ☐ Maternity ☐
d) Date of Injury/Date Disease first detected/Date of Delivery: D D M M Y Y Y Y
e) Date of admission D D M M Y Y Y Y f) Time: H H M M g) Date of Discharge D D M M Y Y Y Y h) Time: H H M M
i) Name of treating doctor Dr. Hitesh Tawari Diagnosis Fracture of front tooth
j) If injury give cause: Self ☐ inflicted ☒ Road Traffic Accident ☐ Substance Abuse /Alcohol Consumption ☐
i) If Medico legal: Yes ☐ No ☒ ii) Reported to police: Yes ☐ No ☒
iii) MLC report and Police FIR attached: Yes ☐ No ☒ j) System of Medicine

"Claim with Bajaj Allianz General Insurance Co Ltd"

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

i. Pre-Hospitalisation Expenses: Rs.

iii. Post-Hospitalisation Expenses: Rs.

v. Ambulance Charges: Rs.

ii. Hospitalisation Expenses Rs.

iv. Health checkup cost Rs.

vi. Others (code) Rs.

Total Rs.

vii. Pre-Hospitalisation period: days

viii. Post Hospitalisation period: days

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

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily Cash Rs.

iii. Critical illness Benefit Rs.

v. Pre/Post hospitalisation lump sum benefit Rs.

ii. Surgical Cash Rs.

iv. Convalescence Rs.

vi. Others Rs.

Total Rs.

Claim Documents Submitted – Check List

- ☒ Claim Form Duly Signed ☐ Copy of claim intimation if any ☒ Original Hospital Main Bill
- ☐ Original Hospital Breakup Bill ☐ Original Hospital Bill Payment Receipt ☒ Original Hospital Discharge Summary/Pharmacy Bill
- ☐ Operation Theater Notes ☐ ECG ☐ Original Doctor's Prescriptions
- ☐ Original Doctors request for investigation reports (including CT/MRI/USG/HPE) ☐ Others
- ☐ Cancelled blank cheque leaf with payee name printed. If name of the payee is not printed on the cheque leaf please attach copy of the first page of the bank passbook.

DETAILS OF BILLS ENCLOSED

Sr.No	Bill No	Date	Issued by	Towards	Amount (Rs)
1	FB24000129	DD MM YY	Hospital	Hospitalisation Main Bill	1 6 9 0 0
2		DD MM YY		Pre-Hospitalisation Bills: Nos	
3		DD MM YY		Post-Hospitalisation Bills: Nos	
4		DD MM YY		Pharmacy Bills	
5		DD MM YY			
6		DD MM YY			
7		DD MM YY			
8		DD MM YY			
9		DD MM YY			
10		DD MM YY			

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) Name of the Account Holder (As per Bank Account): PRAJJWAL TAWRI

b) Account no (As appearing in the cheque book): 5 9 1 8 0 1 0 0 0 0 0 6 5 7

c) Bank Name: BANK OF BARODA

d) Branch Name & Address: BANK OF BARODA, GANJPARA BRANCH PULGAUN ROAD, GANJPARA CHOWK, DURG(C.G.)

e) Account Type: Saving ☒ Current ☐ Cash Credit ☐

f) MICR No: 4 9 1 0 1 2 0 0 5

g) IFSC Code: BARB0GANJPA

h) PAN: B N E P T 7 5 5 2 A

i) Cheque / DD Payable Details:

j) CKYC No:

k) I/We authorize Insurance Company/TPA to contact me/us through SMS/Email/WhatsApp for any update on this claim.

DECLARATION

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 with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize Bajaj Allianz General Insurance Company Limited, 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.

DECLARATIONS – CLAIM FORM

1. For retail policies/individual customers:

Consent/Declaration to be added in proposal and claim for CKYC no.:

I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or National Securities Depository Limited Portal for the purpose of undertaking KYC verification.

2. For Juridical person/non-individual customer:

Consent/Declaration to be added in proposal and claim for CKYC no.:

I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or Goods and Service Tax Portal or Ministry Of Corporate Affairs Portal or National Securities Depository Limited portal for the purpose of undertaking KYC.

3. For Group Policies:

Consent/Declaration to be added in claim form CKYC no.:

I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry for the purpose of undertaking KYC


4. For Juridical person/non-individual customer and Group Policies:

Consent/Declaration to be added in claim form CKYC no.:

I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC

Date: 08/01/2025

Place: DURG



Signature of the Insured

TO BE FILLED IN BY THE HOSPITAL

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

Please include the original preauthorization request form in lieu of PART-A. (to be filled in block letters)

DETAILS OF HOSPITAL

- #### DETAILS OF THE PATIENT ADMITTED

- DETAILS OF AILMENT DIAGNOSED (PRIMARY)**

- d) Pre-Authorization Obtained: Yes ☐ No ☐ e) Pre-Authorization Number:
- f) If authorization by network hospital no obtained, give reason: _____
- g) Hospitalization due to injury: Yes ☐ No ☐ i) If Yes give cause: Self-inflicted: ☐ Road Traffic Accident: ☐ Substance abuse/ alcohol consumption: ☐
- ii) If injury due to Substance abuse/alcohol consumption, Test conducted to establish this: Yes ☐ No ☐ (If Yes attach reports) iii) Medico Legal: Yes ☐ No ☐
- iv) Reported to Police: Yes ☐ No ☐ v) FIR no: _____ vi) If not reported to police give reason: _____

CLAIM DOCUMENTS -CHECK LIST

- | | |
|--|--|
| <input checked="" type="checkbox"/> Claim form duly signed | <input type="checkbox"/> Ingestion reports |
| <input type="checkbox"/> Original Pre-Authorization request | <input type="checkbox"/> CT/MR/USG/HPE investigation report |
| <input type="checkbox"/> Copy of Pre-Authorization letter | <input type="checkbox"/> Doctor's reference slip for investigation |
| <input type="checkbox"/> Copy of photo ID card of patient verified by hospital | <input type="checkbox"/> ECG |
| <input type="checkbox"/> Hospital discharge summary | <input type="checkbox"/> Pharmacy bills |
| <input type="checkbox"/> Operation theatre notes | <input type="checkbox"/> MLC report & Police FIR |
| <input checked="" type="checkbox"/> Hospital main bill | <input type="checkbox"/> Original death summary from hospital where applicable |
| <input type="checkbox"/> Hospital break up bill | <input type="checkbox"/> Any other, please specify |

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON NETWORK HOSPITAL)

- a) Address of hospital: 4/1 Priyadaashini, Parisar, opposite Supela Thana, G.E. Road
City: Bhilai State: C.G. Pin Code: 490023 Phone No: 0788-7018080 c) Registration no with State Code: _____
d) Hospital PAN: _____ e) Number of Inpatient beds: Facilities available in hospital: i) OT: Yes ☐ No ☐ ii) ICU: Yes ☐ No ☐
iii) Others: _____

DECLARATION BY THE HOSPITAL: (PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in the Claim Form is true and correct to the best of our knowledge and belief, and that we have not made any false and untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Plate: 341a

Signature and _____ Authority