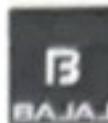


"Claim with Bajaj Allianz
General INSURANCE
Co Ltd"

Bajaj Allianz General Insurance Co. Ltd.
Bajaj Allianz House, Airport Road, Yerwada, Pune -
For more details, log on to : www.bajajallianz.com

Email Id: bajigchelp@bajajallianz.co.in
Toll free no: 1800-209-5858
020-30305858



Allianz

Caringly yours

(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:	O 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:			
e) Company Name:	DELOITTE CONSULTING INDIA PRIVATE LIMITED		
d) Customer ID:			
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 U A L I S H D 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

SECTION A

DETAILS OF INSURANCE HISTORY

SECTION E

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name of the Patient: PRAJJWAL TAWRI

b) Health ID card no of the Patient: DCI-25-50666977

c) Gender: Male Female d) Age: years months e) Date of Birth

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: j) Email ID: PTAWRI@DELOITTE.COM

10

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] [2] [0] [2] [4]

e) Date of admission [D] [D] [M] [M] [2] [0] [2] [4] h) Time [H] [H] [M] [M] g) Date of Discharge [D] [D] [M] [M] [2] [0] [2] [4] h) Time [H] [H] [M]

f) Name of treating doctor Dr. Hitesh Tawari Diagnosis Fracture of front tooth

g) 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

M

"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.

--	--	--	--	--	--

vii. Pre-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. Hospitalisation Expenses Rs.

1	6	9	0	0	
---	---	---	---	---	--

iv. Health checkup cost Rs.

--	--	--	--	--	--

vi. Others (code) Rs.

--	--	--	--	--	--

Total

viii. Post Hospitalisation period: days

--	--	--

Claim Documents Submitted – Check List

- | | | |
|---|---|---|
| <input checked="" type="checkbox"/> Claim Form Duly Signed | <input type="checkbox"/> Copy of claim intimation if any | <input checked="" type="checkbox"/> Original Hospital Main Bill |
| <input type="checkbox"/> Original Hospital Breakup Bill | <input type="checkbox"/> Original Hospital Bill Payment Receipt | <input checked="" type="checkbox"/> Original Hospital Discharge Summary/Pharmacy Bill |
| <input type="checkbox"/> Operation Theater Notes | <input type="checkbox"/> ECG | <input type="checkbox"/> Original Doctor's Prescriptions |
| <input type="checkbox"/> Original Doctors request for investigation reports (including CT/MRI/USG/HPE) | | <input type="checkbox"/> Others |
| <input type="checkbox"/> 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)				
		1D	5D	1M	2M	2Y	4Y			1	6	9	0	0
1	F824000129	D	D	M	M	Y	Y	Hospital	Hospitalisation Main Bill					
2		D	D	M	M	Y	Y		Pre-Hospitalisation Bills: Nos					
3		D	D	M	M	Y	Y		Post-Hospitalisation Bills: Nos					
4		D	D	M	M	Y	Y		Pharmacy Bills					
5		D	D	M	M	Y	Y							
6		D	D	M	M	Y	Y							
7		D	D	M	M	Y	Y							
8		D	D	M	M	Y	Y							
9		D	D	M	M	Y	Y							
10		D	D	M	M	Y	Y							

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 | 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: B | A | R | B | 0 | G | A | N | J | P | A |

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.

SECTION E

SECTION F

SECTION G

SECTION H

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

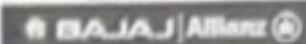
Date: [08/01/2025]

Place: DURG

Signature of the Insured

Claim with Bajaj Allianz General
Insurance Co Ltd Caringly yours

Bajaj Allianz General Insurance Co. Ltd.
Bajaj Allianz House, Airport Road, Versova, PUNE - 411006 Reg. No. 113 | CIN L661089400001C875129
For more details, log on to: www.bajajallianz.com
Email id: customerservice@bajajallianz.co.in, **Toll free no.** 1800-209-5858, 020-30305858



CLAIM FORM- PART B

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

- a) Name of the hospital: VAYAM HEALTH CARE
b) Hospital ID: DURG10375/NH c) Type of hospital: Network Non-Network (If non-network fill section E)
d) Name of treating doctor: DR. HITESH TAWARI
e) Qualification: _____ f) Registration No with State Code: _____ g) Phone No: 7880082991
h) Rohini Code: _____ i) NABH CODE: _____ j) State Level Certificate: _____
k) Higher Level Certificate: _____ l) National Quality Assurance Standards: _____ m) National Health System Resource Center: _____

DETAILS OF THE PATIENT ADMITTED

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

	ICD 10 Codes	Description		ICD 10 PCS	Description
i) Primary Diagnosis:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Fracture of upper left arm.	i) Procedure 1:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
ii) Additional Diagnosis:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		ii) Procedure 2:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
iii) Co-morbidities:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		iii) Procedure 3:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
iv) Co-morbidities:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		iv) Details of Procedure:		

- d) Pre-Authorization Obtained: Yes No e) Pre-Authorization Number: _____

f) If authorization by network hospital not 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"/> Original Pre-Authorization request
<input type="checkbox"/> Copy of Pre-Authorization letter
<input type="checkbox"/> Copy of photo ID card of patient verified by hospital
<input type="checkbox"/> Hospital discharge summary
<input type="checkbox"/> Operation theatre notes
<input checked="" type="checkbox"/> Hospital main bill
<input type="checkbox"/> Hospital break up bill | <input type="checkbox"/> Ingestion reports
<input type="checkbox"/> CT/MR/USG/HPE investigation report
<input type="checkbox"/> Doctor's reference slip for investigation
<input type="checkbox"/> ECG
<input type="checkbox"/> Pharmacy bills
<input type="checkbox"/> MLC report & Police FIR
<input type="checkbox"/> Original death summary from hospital where applicable
<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 Paivaladaoshin, Paarshat, opposite Supela Thana, G.E. Road
City: Bhilai State: C.G. Pin Code: 490023 Phone No: 0788-4018080 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. Any false and untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: 10/8/01:25

Place: China



Signature in
the margin