

(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: 06-26-1919-8403-00000280 b) Sl. No/Certificate No: _____
 c) Company TPA ID No: _____ d) Customer ID: _____
 e) Company Name: DELOITTE CONSULTING INDIA PRIVATE LTD. f) Employee No: 703063
 g) Name: PRAJWAL TAWRI
 h) Address: H-211, PATANJALI SHOP GANJPARA SATTICH
OURA NEAR HANUMAN MANDIR
 City: DURG State: GUJARAT Pin Code: 491001
 Phone No: 83490082028 Email ID: Ptawri@deloitte.com

SECTION A

SECTION B

SECTION C

SECTION D

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim / 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: DDMMYYYY
 Diagnosis _____
 e) Previously covered by any other Mediclaim / Health Insurance: Yes No
 f) If yes, Company Name: _____

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name of the Patient: PRAKASH TAWRI
 b) Health ID card no of the Patient: DCI-26-50666977D
 c) Gender: Male Female d) Age: years 61 months 06 e) Date of Birth 01/05/1964
 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: 9425244402 j) Email ID: Praakash.Tawri@gmail.com

DETAILS OF HOSPITALIZATION

a) Name of Hospital where Admitted: SHREE MEDISHINE HOSPITAL
 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/Disease first detected/Date of Delivery: DDMMYYYY
 e) Date of admission 19/08/2028 f) Time 02:22 g) Date of Discharge 20/08/2028 h) Time 04:29
 i) Name of treating doctor Dr. AKSHAY BAID Diagnosis OLD CVA
 j) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse /Alcohol Consumption
 ii) If Medico legal: Yes No
 iii) MLC report and Police FIR attached: Yes No j) System of Medicine _____

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

i. Pre-Hospitalisation Expenses: Rs. 60000

iii. Post-Hospitalisation Expenses: Rs. 60000

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.

iv. Health checkup cost Rs.

vi. Others (code) Rs.

Total Rs.

viii. Post Hospitalisation period: days

SECTION E

ii. Surgical Cash Rs.

iv. Convalescence Rs.

vi. Others Rs.

Total Rs.

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 checked="" 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"/> | <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)
1		D D M M Y Y		Hospitalisation Main Bill	
2		4 01 01 25		Pre-Hospitalisation Bills: Nos	6 0 0 0 0 0
3		4 01 01 25		Post-Hospitalisation Bills: Nos	6 0 0 0 0 0
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): 5918010000657
 c) Bank Name: BANK OF BARODA
 d) Branch Name & Address: BANK OF BARODA, GANJPARA BRANCH, DURG (C.G.)
 e) Account Type: Saving Current Cash Credit
 f) MICR No. 441612005
 g) IFSC Code: BARB0GANJPA
 h) PAN: BNEPT7552A
 i) Cheque / DD Payable Details: _____
 j) CKYC No. _____

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 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

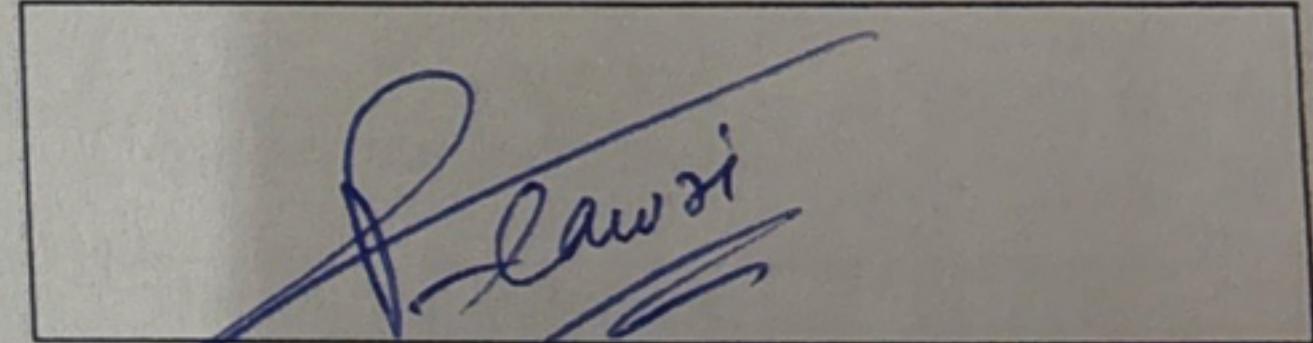
4. For Juridical person/non-individual customer and Group Policies:

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: 05/10/2023

Place:

DURG

Signature of the Insured