CLAIM FORM FOR GROUP MEDICLAIM POLICY

Policy No: : **Claim No: 351063**

1. Name of the Employee	Harikrushna Amitbhai Lakhani
2. Bank Details	Name of the bank : HDFC BANK LTD. Branch / Place : Mumbai Account No : 12511140001677
3. E mail ID	harikrushna.lakhani@ril.com
4. Contact Telephone / Mobile No.	+919537004004
5. Name of the insured Person (in respect of whom the claim is made)	Amit Lakhani
6. A) Name of TPA B) TPA ID Card No.	DHS 5028647549
7. Relationship to the employee	Father
8. Nature of disease / illness contracted or injury suffered:	Flank Lipoma
9. A) Name & address of the hospital / nursing home / clinic B) Registration No. : C) Date of Admission : D) Date of Discharge :	MADHAV HOSPITAL OPP. S.T.STATION,JAMNAGAR GUJJAM202400037PRN 16.12.2024 17.12.2024

10. Schedule of expenses incurred by the claimant under hospitalisation/domiciliary hospitalisation (to be supported by bills/receipts, cash memoes etc.)

	Expenses incurred during hospitalisation	Pre Hospitalisation expenses (Rs)	Post Hospitalisation expenses (Rs)	Total(Rs)
Hospitalisation Benefit	17,696.00	2,650.00	975.00	21,321.00
Domiciliary Hospitalisation				

Declaration

I hereby agree,affirm and declare that :

(a) The statements / information given /stated by me / us in this claim form are true, correct and complete.

(b) No material information which is relevant to the processing of the claim of which in any manner has a bearing on the claim has been withheld or not disclosed.

(c) In case of Maternity benefits extension : I hereby declare that at the time of delivery covered by this claim, I did not have more than two / three living children.

(d) If I have given/made any false or fraudulent statement / information or suppressed or concealed or in any manner failded to disclose material information that I shall not be entitled to all / any rights to recover thereunder in respect of any or all claims, past, present or future.

(e) The receipt of this claim form / other supporting / related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further / additional information in respect of the claim.

P.T.O.

In support of the claim, I enclose the following documents (please indicate by ✓)

✓ 1. Original Discharge Card.
✓ 2. Original Hospitalization bill giving breakup.
✓ 3. Original stamped receipt for the above bill.
✓ 4. Attending Dr. / Specialist's / Anesthetist's original bills & stamped receipt, if not included in the hospital bill.
5. In case of Dental / Eye OPD treatment, Doctor's bill & receipt.
✓ 6. Original Chemists bills.
✓ 7. Prescriptions.
✓ 8. Diagnostic Reports.
9. Room Tariff Card,duly signed by Hospital Authority.
✓ 10. C Form.
✓ 11. Indoor case papers
12. Any other document.

Important:
Since it is a pre-requisite for admission of claims under the policy that the Hospital / Nursing Home / Clinic where the insured Person was admitted, is registered with Local Authorities, it is necessary for the claimant to ensure that the Hospital / Nursing Home / Clinic indicates the Registration No: on the Bill-Cum-Receipt issued by them.

Dated at : 11.03.2025

Signature of the Claimant

Employee Code : 10032335
Level : J
Date of Joining : 04.10.2011
Company Name : Jamnagar U & P Pvt Ltd