

## **National Insurance Company Limited**

Regd. Office 3, Middleton Street, Post Box 9229, Kolkata 700 071

National Mediclaim Policy
CLAIM FORM - PART A
TO BE FILLED IN BY THE INSURED
The issue of theis form is not to be taken as admission of liability

DETAILS OF DOMARY MOURED														
DETAILS OF PRIMARY INSURED														
a) Policy no:	<del>                                     </del>	<del>                                     </del>		b) Si	. No/ Certificate No	0:					Ш			
c) Company/ TPA ID No:	<del>                                     </del>	+ + + +												
d) Name:				44					Щ	_	<u> </u>	_		щ
e) Address:														
City:				State										ШШ,
Pin Code:	Phone No:				Er	mail ID:								
DETAILS OF INSURANCE HISTORY														
a) Currently covered by any other Mediclaim/ Health Insural	nce: Yes	No	b) Date of commer	ncement of first	insurance without	break:	] [							
c) If yes, company name:			Policy No:											] :
Sum Insured (₹):	d) Hav	e you been hospitalize	d in the last four year	s since inception	on of the contract?	Yes	No	Date:						
Diagnosis:					e) P	reviously covered	by any other M	ediclaim/ He	ealth Insu	rance :			Yes	No
f) If yes, Company Name :				•										_
DETAILS OF INSURED PERSON HOSPITALIZED														
a) Name :				т т				$\overline{}$	П	$\overline{}$	ТТ	$\overline{}$	T	一一
b) Gender: Male Female	d) Date of Birth:			Sum insured:	₹			i) (	CB (if any	1	$\pm \pm$	+	+	HH
f) Relatuionship to Primary Insured: Self	Spouse Chi	d Father	Moth		=	(Please specify)	+	'',	JD (II dilly	<u> </u>				
				=										
<u> </u>	nployed Homemaker	Student	Retire	su	Other	(Please specify)	<del>                                     </del>		. т	_	1 1	_		
h) Address (if different from above):	<del>                                     </del>	+++	<del>-      </del>	++	++	+++	<del>1   .</del>		ዙ	+	<del>   </del>	+	+	##
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City:	<del>                                     </del>	<del>       </del>	<del>-      </del>	State	$\vdash \vdash$	<del></del>	1 1			<u> </u>	1 1		1	الحسا
Pin Code:	Phone No:				Er	mail ID:								
DETAILS OF HOSPITALIZATION														
a) Name of Hospital where Admitted:				$\perp \perp$								Τ		
b) Room category occupied: D	ay Care Single occ	cupancy	Twin shari	ng		3 or more beds pe	r room							
c) Hospitalization due to:	Illness Maternity		d) D	ate of injury/ D	ate Disease first de	etected/ Date of D	elivery:							
e) Date of Admission:	f) Time:	:		g) Date of I	Discharge:				h)	Time:			: 🗀	
i) If injury, give cause: Self inflicted	Road Traffic Accident	1	Substance ab	use / Alcohol C	onsumption	1	i. If Medico Le	gal:	Yes	No				
ii. Reported to police: Yes No	iii. MLC Report & Police	FIR attached:	Yes No	j) Sy	stem of medicine:									
DETAILS OF CLAIM														
a) Details of treatment expenses claimed								Clain	n Docum	ents Sul	bmitted-	Check I	List:	
i. Pre Hospitalization Expenses ₹		ii Pre	hospitalization period		days			- Cium		ormDuly		01100K 1		
i.Room, boarding, nursing expenses	days @ ₹	_	imit of 1% of SI per o		_			H	:		n intimatio	on if on	0.4	
<del></del>		="				n limit of 25% of S illness	for any one	-	:	Main bil		ni, ii aii	y	
ii. ICU, boarding, nursing expenses	days @ ₹		imit of 2% of SI per o	iay, max ₹10,0	UUJ				Hospital					
			Landanian Bank of OFO	- ( 0) (										
i. Medical practitioner's fees ₹		M	laximum limit of 25%	of SI for any o	ne illness			Ē	Hospital	Break-u	p bill			
i. Anaesthesia, blood, oxygen, OT ₹		М	faximum limit of 25%	of SI for any o	ne illness			Ē	Hospital Hospital	Break-u Dischar		ary		
i. Anaesthesia, blood, oxygen, OT ₹		М	taximum limit of 25%	of SI for any o	ne illness				Hospital Hospital Pharma	Break-u Discharg	p bill ge Summ	ary		
i. Anaesthesia, blood, oxygen, OT  ii. Surgical appliances  ₹  iii. Medicines, drugs  ₹		М	laximum limit of 25%	of SI for any o	ne illness				Hospital Hospital Pharma Operatio	Break-u Dischar	p bill ge Summ	ary		
i. Anaesthesia, blood, oxygen, OT ₹		М	laximum limit of 25%	of SI for any o	ne illness				Hospital Hospital Pharma	Break-u Discharg	p bill ge Summ	ary		
i. Anaesthesia, blood, oxygen, OT  ii. Surgical appliances  ₹  iii. Medicines, drugs  ₹		М	laximum limit of 25%	of SI for any o		n limit of 50% of S	for any one		Hospital Hospital Pharma Operation	Break-u Dischare cy Bill on Theatr	p bill ge Summ			
i. Aneasthesia, blood, oxygen, OT  ii. Surgical appliances  ₹  iii. Medicines, drugs  iv. Diagnostic test  ₹		М	laximum limit of 25%	of SI for any o		n limit of 50% of S illness	for any one		Hospital Hospital Pharma Operatio ECG Doctor's	Break-u Discharg cy Bill on Theatr request	p bill ge Summ re Notes	igation	T /	
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## **National Insurance Company Limited**

Regd. Office 3, Middleton Street, Post Box 9229, Kolkata 700 071

	GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)					
DATA ELEMENT	DESCRIPTION	FORMAT				
	SECTION A - DETAILS OF PRIMARY INSURED					
a) Policy No.	Enter the policy number	As allotted by the insurance company				
b) SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization				
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.				
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name				
e) Address	Enter the full postal address	Include Street, City and Pin Code				
	SECTION B - DETAILS OF INSURANCE HISTORY	• • •				
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No				
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format				
c) Company Name	Enter the full name of the insurance company	Name of the organization in full				
Policy No.	Enter the policy number	As allotted by the insurance company				
Sum Insured	Enter the total sum insured as per the policy	In rupees				
d) Have you been Hospitalized in the last 4 years since inception of the contract?	Indicate whether hospitalized in the last 4 years	Tick Yes or No				
Date	Enter the date of hospitalization	Use mm-yy format				
Diagnosis	Enter the diagnosis details	Open Text				
e) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No				
f) Company Name	Enter the full name of the insurance company	Name of the organization in full				
· · ·	SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED	present an argumenton militar				
a) Name	Enter the full name of the patient	Surname, First name, Middle name				
b) Gender	Indicate Gender of the patient	Tick Male or Female				
c) Age	Enter age of the patient	Number of years and months				
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format				
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.				
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.				
g) Address	Enter the full postal address	Include Street, City and Pin Code				
h) Phone No	Enter the phone number of patient	Include STD code with telephone number				
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address				
,	SECTION D - DETAILS OF HOSPITALIZATION	complete e mail address				
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full				
b) Room category occupied	Indicate the room category occupied	Tick the right option				
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option				
d) Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date	Use dd-mm-yy format				
e) Date of admission	Enter date of admission	Use dd-mm-yy format				
f) Time	Enter time of admission	Use hh:mm format				
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format				
h) Time	Enter time of discharge	Use hh:mm format				
i) If Injury give cause	Indicate cause of injury	Tick the right option				
If Medico legal	Indicate cause of injury  Indicate whether injury is medico legal	Tick Yes or No				
Reported to Police	Indicate whether police report was filed	Tick Yes or No				
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No				
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text				
e e	SECTION E - DETAILS OF CLAIM	1-1				
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)				
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No				
c) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)				
d) Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option				
.,	SECTION F - DETAILS OF BILLS ENCLOSED	Thore are right option				
Indicate which bills are enclosed with the amounts in rupees						
	SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT					
a) PAN	Enter the permanent account number	As allotted by the Income Tax department				
b) Account Number	Enter the bank account number	As allotted by the bank				
c) Bank Name and Branch	Enter the bank name along with the branch					
d) Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization in full				
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full				
	SECTION H - DECLARATION BY THE INSURED	·				
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign		· · · · · · · · · · · · · · · · · · ·				