CLAIM FORM FOR HEALTH INSURANCE POLICIES OF THE NEW INDIA ASSURANCE CO LTD- PART A TO BE FILLED IN BY THE INSURED The issue of this Form is not to be taken as an admission of liability

(To be filled in block letters)

TAILS OF PRIMARY INSURED: POLICY NO. 1 A 1 6 0 0 3 4 1 9 0 4 0 0 0 0 0	O T & t) St. No/ Certificate No.	
Company/ TPA ID No.		
Name: PADMAVATHIS	STRAME MIEDULE NA	
	3 RD STREET. SANKARA	PURAL
SITHALAPAKKAM		
City Z HENNAT	State TAMILNADO	
Pin Code: 6 0 0 1 2 6 Phone No: 0 9 0 9 4		ail.com
AILS OF INSURANCE HISTORY:		
Currently covered by any other Medictaim / Health Insurance: Yes Vo b) Date of corm	mericement of first Insurance without break 01 64 19	
	slicy No.	
m Insured (Ps.) d) Have you been hospitalized in the last four	years since inception of the contract? Yes 100 Date: 107 VI	
grosis.	e) Previously covered by any other Mediclaim / Health insurance	ce: Yes W
f yes, Company Name		
TAILS OF INSURED PERSON HOSPITALIZED:		
Name PADMAVATHIS FA		
Gender, Male Female c) Age years 5 8 months 6	6 d) Date of Birth: 1 1 0 8 59	
Relationship to Primary insured. Self Spouse Onlid Father	Mother Other (Please Specify)	
Occupation: Service Self Employed Homemaker Student	Retired Other (Please Specify)	
Acidress (if different from above):		
City:	State:	
Pin Code: Phane No:	E-mail ID:	
TAILS OF HOSPITALIZATION:		
Name of Hospital where Admitted: APOLLO HOSPL	7.BL	
	Twin sharing 3 or more beds per room	_
hospitalization due to: Injury Illness Matemity d) Date	e of Injury / Date Disease first detected /Date of Delivery: 2607	
6.5 25/2002 Capital (1998) 10 (2007) 25		9
Date of Admission.	b) g) Date of Discharge: D D B B B A N h) Time: 19	# : # K
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FAMILY HEALTH PLAN INSURANCE TPA LIMITED

Srinilaya - Cyber Spazio, Ground Floor, Road No. 2, Banjara Hills, Hyderabad - 500 034

Toll-free: 1800-425-4033 (or) 1800-102-4033 Fax: 040 23541400; Website: www.fhpl.net

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIMS UNDER GROUP POLICY

[Please tick (P) the appropriate box] Name of the Claimant: ARPUTHAREJ 14160034190400000011 Employe Id : 70039925 Insurance Company: THE NEW DNOTH ASSURANCE CO. LTD UHID Number: NIAC. 20396300 Ouly filled in Claim Form Pre-hospitalization prescriptions Photocopy of ID card Original prescription / doctor notes of previous treatment for the presenting complaint For Fresh Joinee: Endorsement letter from the Manager-HR regarding date of Date of previous operation (if any) along with copy of joining of the member / employee / dependent discharge summary For Death Cases: General: Attested copy of death summary in pre-printed Original copy of consolidated bill on pre-printed stationery with serial number and IP number of hospital, with breakup stationery of hospital signed by the treating doctor with hospital seal and registration number Original copy of the receipt of payment Attested copy of death certificate from competent authority All original prescriptions for the bills attached Legal heir certificate / Letter from the underwriting office All the Original Investigation Reports directing FHPL to settle the claim in the name of the Original Discharge summary in pre-printed stationery nominee / dependent(s) hospital, duly signed by the treating doctor, with hospital For Maternity Cases: seal and registration number Original copy of treating doctor certificate regarding Original invoice for Implants (viz. Stent / PHS mesh / IOL obstetric history (Gravida, Para, Living children, Abortions, etc.) Death) First consultation letter for the presenting complaints For RTA: Original copies of doctor's consultation prescription / notes Attested copy of MLC report Treating Doctor's certificate regarding presenting Attested copy of FIR complaints its etiology, past history of presenting Original copy of treating doctor's certificate with complaints along with duration circumstances and injuries sustained due to RTA Cancelled cheque along with IFSC details (or) copy of the Original copy of treating doctor's certificate for any Bank pass book. evidence of influence of alcohol / other narcotics substance Submission of photo Id & address proof If claim amount during the accident is above Rs.1 Lakh. Do you have any other Health Insurance Policy? Yes / No If yes, please specify policy number: Sum Insured: Insurance Company: Disclaimer: Undertaking: I / we hereby confirm that the above -mentioned documents We acknowledge receipt of your claim and confirm that it in support of the claimed amount have been submitted in has been registered with us on the basis of the above full and final. No other documents would be submitted on mentioned documents. However, the a later date, that will alter / enhance the claimed value. acknowledgement does not guarantee settlement / payment of the claimed amount. This claim will be subjected to pass through medical and commercial scrutiny, which may Place: CHENNAT call for additional documents that needs to be submitted Full Name: ARPUT HAR OJ within the stipulated time frame on intimation. Address: #34, UZJAA AVENUE 3RPSTREET SANKARAPURAM, SITHALAPAKKAM City: CHENNAI Pin: 600026 Contact Number: (Res) Email: aputh 132 @gmail. com Date: Place: