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)

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No: 141600341904000000016 b) Sl. No/ Certificate No:
c) Company/ TPA ID No:
d) Name: PADMAVATHI S
e) Address: 34, VIJAY AVENUE 3RD STREET, SANKARAPURAM SITHALAPAKKAM
City: CHENNAI State: TAMILNADU
Pin Code: 600126 Phone No: 09094983648 Email ID: arputh123@gmail.com

SECTION B

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: ☐ Yes ☑ No b) Date of commencement of first Insurance without break: 01 04 19
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:
Diagnosis: e) Previously covered by any other Mediclaim / Health insurance: ☐ Yes ☑ No
f) If yes, Company Name:

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: PADMAVATHI S
b) Gender: Male ☐ Female ☑ c) Age: years 58 months 06 d) Date of Birth: 11 08 59
e) Relationship to Primary insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ (Please Specify)
f) Occupation: Service ☐ Self Employed ☐ Homemaker ☑ Student ☐ Retired ☐ Other ☐ (Please Specify)
g) Address (if different from above):
City: State:
Pin Code: Phone No: E-mail ID:

SECTION D

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted: APOLLO HOSPITAL
b) Room Category occupied: Day care ☑ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐
c) Hospitalization due to: Injury ☐ Illness ☑ Maternity ☐ d) Date of Injury / Date Disease first detected /Date of Delivery: 26 07 19
e) Date of Admission: f) Time: g) Date of Discharge: h) Time:
i) 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 & Police FIR attached: ☐ Yes ☐ No j) System of Medicine:

SECTION E

DETAILS OF CLAIM:

a) Details of the treatment expenses claimed:

i. Pre-hospitalization Expenses:	Rs. 33920	ii. Hospitalization Expenses:	Rs.
iii. Post-hospitalization Expenses:	Rs.	iv. Health-Check up Cost:	Rs.
v. Ambulance Charges:	Rs.	vi. Others (code):	Rs.
		Total	Rs. 33920
vii. Pre-hospitalization period:	days 3	viii. Post-hospitalization period:	days

b) Claim for Domiciliary Hospitalization: ☐ Yes ☐ No (If yes, provide details in annexure)
c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily Cash:	Rs.	ii. Surgical Cash:	Rs.
iii. Critical Illness Benefit:	Rs.	iv. Convalescence:	Rs.
v. Pre/Post hospitalization Lump sum benefit:	Rs.	vi. Others:	Rs.
		Total	Rs.

Claim Documents Submitted- Check List:
- ☑ Claim Form Duly signed
- ☐ Copy of the claim intimation, if any
- ☐ Hospital Main Bill
- ☑ Hospital Break-up Bill
- ☑ Hospital Bill Payment Receipt
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bill
- ☐ Operation Theatre Notes
- ☑ ECG
- ☑ Doctor's request for investigation
- ☐ Investigation Reports (Including CT / MRI / USG / HPE)
- ☑ Doctor's Prescriptions
- ☐ Others

SECTION F

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1.	334970	26 07 19	APOLLO	Hospital Main Bill	
2.	910874	26 07 19	APOLLO	Pre-hospitalization Bills 8 Nos	33920
3.	334305	26 07 19	APOLLO	Post-hospitalization Bills __Nos	
4.	911094	27 07 19	APOLLO	Pharmacy Bills	
5.	911091	27 07 19	APOLLO		
6.	334707	28 07 19	APOLLO		
7.	911259	28 07 19	APOLLO		
8.	334153	28 07 19	APOLLO		
9.					
10					

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT: ACC. NAME 'ARPUTHARAJ'

DHBPS0057N 50100014617337
c) Bank Name and Branch: HDFC BANK GANDHI BAZAR BRANCH
d) Cheque/ DD Payable details: ARPUTHARAJ e) IFSC Code: HDFC0000446

(IMPORTANT: PLEASE TURN OVER)

Checklist for submission of Claim

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: ARPUTHARAJ Group Name :

UHID Number: NIAC.20396900 Employe Id : 70039925 Policy Number: 141600341904000000 16

Insurance Company: THE NEW INDIA ASSURANCE CO. LTD No. of Enclosures:

- [x] Duly filled in Claim Form
- [x] Photocopy of ID card

For Fresh Joinee:

Endorsement letter from the Manager-HR regarding date of joining of the member / employee / dependent

General:

- [x] Original copy of consolidated bill on pre-printed stationery with serial number and IP number of hospital, with breakup
- [ ] Original copy of the receipt of payment
  All original prescriptions for the bills attached
- [x] All the Original Investigation Reports
- [ ] Original Discharge summary in pre-printed stationery of hospital, duly signed by the treating doctor, with hospital seal and registration number
- [ ] Original invoice for Implants (viz. Stent / PHS mesh / IOL etc.)
- [ ] First consultation letter for the presenting complaints
- [x] Original copies of doctor's consultation prescription / notes Treating Doctor's certificate regarding presenting complaints its etiology, past history of presenting complaints along with duration
- [ ] Cancelled cheque along with IFSC details (or) copy of the Bank pass book.
- [ ] Submission of photo Id & address proof If claim amount is above Rs.1 Lakh .

- [x] Pre-hospitalization prescriptions
- [x] Original prescription / doctor notes of previous treatment for the presenting complaint
- [ ] Date of previous operation (if any) along with copy of discharge summary

For Death Cases:

- [ ] Attested copy of death summary in pre -printed stationery of hospital signed by the treating doctor with hospital seal and registration number
- [ ] Attested copy of death certificate from competent authority
- [ ] Legal heir certificate / Letter from the underwriting office directing FHPL to settle the claim in the name of the nominee / dependent(s)

For Maternity Cases:

- [ ] Original copy of treating doctor certificate regarding obstetric history (Gravida, Para, Living children, Abortions, Death)

For RTA:

- [ ] Attested copy of MLC report
- [ ] Attested copy of FIR
- [ ] Original copy of treating doctor's certificate with circumstances and injuries sustained due to RTA
- [ ] Original copy of treating doctor's certificate for any evidence of influence of alcohol / other narcotics substance during the accident

Do you have any other Health Insurance Policy? ~~Yes~~ / ~~No~~ If yes, please specify policy number:
Sum Insured: Insurance Company:

Undertaking:

I / we hereby confirm that the above -mentioned documents in support of the **claimed amount** have been submitted in full and final. No other documents would be submitted on a later date, that will alter / enhance the claimed value.

Date:
Place: CHENNAI Signature
Full Name: ARPUTHARAJ
Address: #34, VIJAY AVENUE 3RD STREET SANKARAPURAM, SITHALAPAKKAM
City: CHENNAI Pin: 600126
Contact Number: (Res)
(Mobile) 09094983648
Email: arputh193@gmail.com

Disclaimer:

We acknowledge receipt of your claim and confirm that it has been registered with us on the basis of the above - mentioned documents. However, the above acknowledgement does not guarantee settlement / payment of the claimed amount. This claim will be subjected to pass through medical and commercial scrutiny, which may call for additional documents that needs to be submitted within the stipulated time frame on intimation.

Date: Signature Signature
Place: Claimant For FHPL