Medi Assist

REIMBURSEMENT CLAIM FORM

TO BE FILLED BY THE INSURED

The issue of this Form is not to be taken as an admission of liablity

(To be Filled in block letters)

SECTION A | SECTION B | SECTION C

DETAILS OF PRIMARY INSURED:

a) Policy No.: 123456789123 b) Sl. No/ Certificate no.:

c) Company / TPA ID (MA ID)No:

d) Name: AGRWAL ROHIT

e)Address: 218/24 PANDGANJ NEAR PVR CINEMA SUBZI MANDI CHOWK LUCKNOW

City: LUCKNOW State: UTTAR PARDESH

Pin Code 400107 Phone No: 9876543211 Email ID:

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:

Diagnosis: e) Previously covered by any other Mediclaim /Health insurance : ☐ Yes ☐ No

f) If yes, company name:

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: AGRWAL MAHESH

b) Gender Male ✓ Female ☐ c) Age years ☐☐ Months ☐☐ d) Date of Birth 11 09 1959

e) Relationship to Primary insured: Self ☐ Spouse ☐ Child ☐ Father ✓ Mother ☐ Other ☐ (Please Specify)

f) Occupation Service ☐ Self Employed ☐ Home Maker ☐ Student ☐ Retired ☐ Other ☐ (Please Specify)

g) Address (if diffrent from above): 218/24 PANDGANJ NEAR PVR CINEMA SUBZI MANDI CHOWK LUCKNOW

State: UTTAR PARDESH