RELIGARE | Health Insurance
Values that bind

Ab Health Hamesha

Claim Form - 'GROUP CARE'

Part A

1. To be filled in by the Insured.
2. The issue of this Form is not to be taken as an admission of liability.
3. To be filled in block letters.

Section A - Details of Primary Insured

a) Policy No. : ABCDEFGHIJKLMN1234567890101ABXZ

b) SL No./Certificate No.: 8765432142 c) Company/TPA ID No.: XYZAGC1234

d) Name : Anand Kanakaraji Ri
(Surname) (First Name) (Middle Name)

e) Address : 1209 35th B CROSS 4th T Block
JAYANAGAR
City: Bangalore

State : KARNATAKA Pin Code : 560041

Landline : 0080 22343202 Mobile : 7728878762

E-mail : KANANDIEHOTMAIL.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 : 01/01/2018 (DD/MM/YY)

c) If yes, Company Name : SWISS RE AMERICAS

Policy Number : 832A1351BC123 Sum Insured (Rs.): 300000

d) Have you ever been hospitalized in the last 4 years since inception of the contract? ☐ Yes ☐ No

- Date: / / (DD/MM/YY)
- Diagnosis: ERYTHROBLASTOCYS FOETALIS

e) Previously covered by any other Mediclaim/Health Insurance : ☑ Yes ☐ No

f) If yes, Company Name: DADAJI BHAKSHI LIMITED

Section C - Details of Insured Person Hospitalised

Title : ☑ Mr. ☐ Ms.

a) Name : ROMNIE SCREWWALA
(Surname) (First Name) (Middle Name)

b) Gender : ☑ M ☐ F c) Age : 98 / (YY/MM) d) Date of Birth : 01/01/1932

e) Relationship with Primary Insured : ☑ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother
☐ Others (Please Specify) _____

f) Occupation : ☑ Service ☐ Self Employed ☑ Homemaker ☐ Retired ☐ Student ☐ Others (Please Specify) _____

g) Address : 460032 SUBRAMANIYA RD
(If different from above) BANGALORE
City: BANGALORE

State : KARNATAKA Pin Code :

h) Landline : - Mobile :

i) E-mail :