

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. : **87287299**

b) SL No./Certificate No.: c) Company/TPA ID No.: **C3408756**

d) Name : **D.** **GANAPATHI** **SUBRAMANIAM**
(Surname) (First Name) (Middle Name)

e) Address : **1-1-58 PILLAYAR KOVIL STREET**
SIVARAMAPETTAI KODIKURICHI
TENKASI
City: **TENKASI**

State : **TAMILNADU** Pin Code: **627804**

Landline : Mobile: **9486782063**

E-mail : **ganapathi@melissadata.com**

Section B - Details of Insurance History

a) Currently covered by any other Medicaclaim/Health Insurance: ☐ Yes ☒ No

b) Date of commencement of first insurance without break: / / (DD/MM/YYYY)

c) If yes, Company Name :
Policy Number : Sum Insured (Rs.):

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

• Date: / / (DD/MM/YYYY)

• Diagnosis:

e) Previously covered by any other Medicaclaim/Health Insurance: ☐ Yes ☒ No

f) If yes, Company Name:

Section C - Details of Insured Person Hospitalised

Title : ☐ Mr. ☒ Ms.

a) Name : **G.** **VITHYAA** **LAXMIBABY**
(Surname) (First Name) (Middle Name)

b) Gender : ☐ M ☒ F c) Age: / (YY/MM) d) Date of Birth: **03** / **10** / **2024**

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

f) Occupation: ☐ Service ☐ Self Employed ☐ Homemaker ☐ Retired ☐ Student ☒ Others (Please Specify) **just born Baby**

g) Address :
(if different from above)
City:

State : Pin Code:

h) Landline : Mobile:

i) E-mail :

Section D - Details of Hospitalisation

- a) Name of Hospital where Admitted: **A N N A I V E L A N K A N N I M U L T I S P E C I A L T Y**
- b) Room Category occupied : ☐ Day Care ☒ Single Occupancy ☐ Twin Sharing ☐ 3 or more beds per room
- c) Hospitalisation due to : ☐ Injury ☐ Illness ☐ Maternity
- d) Date of Injury/Date Disease first detected/Date of Delivery : **03 / 10 / 2024** (DD/MM/YYYY)
- e) Date of Admission : **03 / 10 / 2024** (DD/MM/YYYY) f) Time of Admission : **05 : 00** (HH:MM)
- g) Date of Discharge : **11 / 10 / 2024** (DD/MM/YYYY) h) Time of Discharge : **15 : 30** (HH:MM)
- i) If Injury, give cause : ☐ Self Inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption
- ii) Reported to Police : ☐ Yes ☐ No
- iii) MLC Report & Police FIR attached : ☐ Yes ☐ No j) System of Medicine : _____

Section E - Details of Claim

Claim made for

Benefit / Optional Extension	Yes / No	Benefit / Optional Extension	Yes / No
Hospitalization Expenses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alternative Treatments (IPD basis)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pre - hospitalization Medical Expenses & Post - hospitalization Medical Expenses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Major Diagnostics	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pre - hospitalization Medical Expenses & Post - hospitalization Medical Expenses Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Domestic Road Ambulance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Maternity Expenses - Delivery Only	<input type="checkbox"/> Yes <input type="checkbox"/> No	Durable Medical Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Maternity Expenses Comprehensive Cover	<input type="checkbox"/> Yes <input type="checkbox"/> No	Maternity Complications	<input type="checkbox"/> Yes <input type="checkbox"/> No
Maternity Expenses - Delivery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Domiciliary Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pre Natal and Post Natal	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cover extended outside India	<input type="checkbox"/> Yes <input type="checkbox"/> No
New Born baby	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	No Corporate Floater	<input type="checkbox"/> Yes <input type="checkbox"/> No
Donor Expenses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Health Check-up	<input type="checkbox"/> Yes <input type="checkbox"/> No
OPD Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alternate Treatments (OPD basis)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Domiciliary Hospitalization	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Cover	<input type="checkbox"/> Yes <input type="checkbox"/> No

a) Details of the treatment expenses claimed

- | | | | |
|---|----------------------|--|----------------------|
| (i) Pre-hospitalization Expenses : Rs. | <input type="text"/> | (xiii) Dental Treatment : Rs. | <input type="text"/> |
| (ii) Hospitalization Expenses : Rs. | <input type="text"/> | (xiv) Alternative Treatments (IPD) : Rs. | <input type="text"/> |
| (iii) Post-hospitalization Expenses : Rs. | <input type="text"/> | (xv) Major Diagnostics : Rs. | <input type="text"/> |
| (iv) Health Check-up cost : Rs. | <input type="text"/> | (xvi) Psychiatric Treatment : Rs. | <input type="text"/> |
| (v) Ambulance Charges : Rs. | <input type="text"/> | (xvii) Patient Care : Rs. | <input type="text"/> |
| (vi) Maternity Benefit : Rs. | <input type="text"/> | (xviii) Durable Medical Equipment : Rs. | <input type="text"/> |
| (vii) Pre - Natal Expenses : Rs. | <input type="text"/> | (xix) Maternity Complication : Rs. | <input type="text"/> |
| (viii) Post - Natal Expenses : Rs. | <input type="text"/> | (xx) Domiciliary Treatment : Rs. | <input type="text"/> |
| (ix) New Born Baby Expenses : Rs. | 67687 | (xxi) Cover extended outside India : Rs. | <input type="text"/> |
| (x) Donor Expenses : Rs. | <input type="text"/> | (xxii) Corporate Floater : Rs. | <input type="text"/> |
| (xi) OPD Treatment : Rs. | <input type="text"/> | (xxiii) Alternate Treatments (OPD basis) : Rs. | <input type="text"/> |
| (xii) Domiciliary Hospitalization : Rs. | <input type="text"/> | (xxiv) HIV Cover : Rs. | <input type="text"/> |

a) Details of the treatment expenses claimed

(xxv) Comprehensive HIV Cover : Rs.
 (xxvi) Others (code) : Rs.
 Total : Rs.

(xxvii) Pre-hospitalization period : days
 (xxviii) 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. (v) Pre/Post hospitalization Lump sum benefit : Rs.
 (ii) Surgical Cash : Rs. (vi) Patient Care : Rs.
 (iii) Critical Illness Benefit : Rs. (vii) Others : Rs.
 (iv) Convalescence : Rs. Total : Rs.

d) Claim Documents Submitted - Checklist

(i) Claim Form Duly signed : ☒ (vii) Pharmacy Bill : ☒
 (ii) Copy of the claim intimation, if any : ☒ (viii) Operation Theatre Notes : ☐
 (iii) Hospital Main Bill : ☒ (ix) ECG : ☐
 (iv) Hospital Break-up Bill : ☒ (x) Doctor's request for investigation : ☐
 (v) Hospital Bill Payment Receipt : ☒ (xi) Investigation Reports (Including CT/MRI/USG/HPE): ☐
 (vi) Hospital Discharge Summary : ☒ (xii) Doctor's Prescriptions : ☐
 (xvi) Others ☐

Section F - Details of Bills Enclosed

S No.	Bill No.	Date	Issued by	Towards	Amount (INR)
1		11/10/2024		Hospital Main Bill	67687
2		(DD/MM/YYYY)		Pre-hospitalization Bills: ___Nos	
3		(DD/MM/YYYY)		Post-hospitalization Bills: ___Nos	
4		(DD/MM/YYYY)		Pharmacy bills	
5		(DD/MM/YYYY)			
6		(DD/MM/YYYY)			
7		(DD/MM/YYYY)			
8		(DD/MM/YYYY)			
9		(DD/MM/YYYY)			
10		(DD/MM/YYYY)			

In case of more details, please attach a separate sheet.

Section G - Details of Primary Insured's Bank Account

a) PAN : BENPG2600G
 b) Account Number : 167822010000013
 c) Bank Name & Branch : UNIONBANKOFINDIA BAKSHAYNAGAR
 d) Cheque/DD payable details :
 e) IFSC Code : UBIN0916781

Section H - Declaration by the Insured

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA/Company, to seek necessary medical information/documents from any hospital/Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills/receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date : 29 / 10 / 2024 (DD/MM/YYYY)

Signature of the Insured : 

Place : BENGALURU