

Date :24th December, 2024

To,
GANAPATHI SUBRAMANIAN D .,
NO345, 12TH CROSS, 1ST BLOCK VISHWAPRIYA LAYOUT, BEGUR ROAD,
,
KARNATAKA,
Bangalore,
Bangalore,
560068.

Subject: "Claim Approval Letter"

Dear Sir/Madam,

We wish to inform you, your claim no. 95097843-01 against policy 87287299 has been approved towards Medical Expenses of "VITHYAALAXMI BABY .". Please refer Annexure I for details.

Policy No.	87287299
Proposer Name	MELISSA DATA CORPORATION
Claimed Amount	7150.00
Bill Amount	7150.00
Amount to be Paid (INR)	6435.00

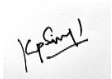
Successful transfer of amount in to your bank account will be considered as full and final settlement of the claim.

In case you require any additional assistance, please visit the Self-help portal at www.careinsurance.com/self-help-portal.html .

Kindly find the attached details of Grievance Redressal Procedure in Annexure attached in email.

With warm regards,

For **Care Health Insurance Limited.**



Authorised Signatory

Care Health Insurance Limited

Regd. Office: 5th Floor, 19 Chawla House, Nehru Place, New Delhi-110019
Correspondence Office: Vipul Tech Square, Tower C, 3rd Floor,
Golf Course Road, Sector-43, Gurugram -122009 (Haryana)

IRDAI Regn. No. 148 | CIN: U66000DL2007PLC161503

REACH US @


Care Health-
Customer App


WhatsApp
8860402452

Self Help Portal:
www.careinsurance.com/self-help-portal.html
Submit Your Queries/Requests:
www.careinsurance.com/contact-us.html

Annexure I

Claim No	95097843-01	AL No.	
Nature of Claim	HNBR_NEW BORN BABY COVER	Hospital ID	75814249
Policy No.	87287299	Corporate Name	MELISSA DATA CORPORATION
Employee ID	00000MD-39	Employee Name	GANAPATHI SUBRAMANIAN D .
Name of Proposer	MELISSA DATA CORPORATION	Name of Patient	VITHYAALAXMI BABY .
Date of admission	03-Oct-2024	Date of Discharge	11-Oct-2024
Name of Hospital	ANNAI VELANKANNI MULTI SPECIALITY HOSPITAL	Claim Amount	7150.00
Hospital Discount (not to be collected from Patient)	0	AL approved Amount	0
Co pay	715.00	Deductible	0
Unpaid Premium Adjustment	0.00		
SI/Benefit Limit Exhausted	0.00	Paid Amount	6435.00

Category-wise Breakup:

S.no	Description	Bill Amount	Admissible Amount	No.of Day/Visits/ Quantity	Rate per day/ Quantity	Deducted Amount
I	Estimated amount/Others	7150	7150			
Total		7150	7150			0

Deduction details:

Bill Number	Requested Amount	Deduction Amount	Deduction Reasons	Deduction Clause	Deduction Remarks
Total deducted amount		0			

*** Please Refer Appendix for the Deduction Clause**

Sum Insured Utilisation

Care Health Insurance Limited

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Sum Insured (SI)
6435

Deduction Clause Appendix

Remark : APPROVED

Note: The amount is towards full and final settlement of the claim submitted by you. For claiming any dis-allowed amount, kindly submit the bills at earliest.

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