

CLAIM FORM OPD - 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)



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Reference No: D021220210226243090 POICTAILS OF INSURED PERSON POICTAILS OF INSURED PERSON Relationship: Self	UHID No.:	2999203918399301000	Section A Employee ID: 03563X					
Details of Name: IBM - EMPLOYEE (ESC) Insured Person's Name: KALYANI CHAVALI Gender: Male Female Diagnosis: Relationship: Self Spouse Child Father Mother Other Address: Landmark: City/Town: District: State: Telephone: Mobile: 9677296489 Pin								
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DETAILS OF BILLS ENCLOSED:						Section I		
No Bill No. Bill Date Bill Amount Remarks 1 31326/2021 06-Nov-2021 500 Consultant Charges								
DECLARATION BY THE INSURED:						Section F		

& authorize TPA / insurance 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, if any.

Signature of the insured: Date: Place:

Note:Claim form, cancelled cheque and all financial documents like Consultation bill/ Receipts and any other bills are required in original hard copy to be submitted at nearest IBM help desk or to be couriered to Medi Assist Bangalore office within 3-4 working days for the final settlement of the claim. Medi Assist Bangalore office address is given below

MEDI ASSIST INSURANCE TPA PRIVATE LIMITED 4th Floor, Tower D, IBC Knowledge Park, Bannerghatta Road, Bengaluru 560 029