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)

Z0009787431

DETAILS OF PRIMARY INSURED Section A

UHID No.: **2999203918399301000** Employee ID: **03563X**

Company Name: **IBM - EMPLOYEE (ESC)** Reference No: **D0212202102262430 90**

DETAILS OF INSURED PERSON Section B

Policy Holders 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 Code: E-Mail:

DETAILS OF CLAIM AND DOCUMENTS TO BE SUBMITTED: Section C

- Duly filled claim form
- Consultation papers (It should have qualifications of the treating doctor)
- Prescriptions of tests advised
- Prescriptions of medicines advised
- Investigation reports
- Bills and payment receipts
- OPD (Dental X-ray) report in case of dental treatment
- Any other documents submitted
- All financial documents should be in original. Photocopies will not be accepted
- ID proof of the insured

DETAILS OF PRIMARY INSURED?S BANK ACCOUNT: Section E

PAN No: Account No: **50**********96**

Bank Name/Branch: **HDFC BANK LTD** Payable details: Cheque/DD

IFSC Code: **H*********9** * please attach a cancelled cheque pertaining to the same

MICR No: * please attach a cancelled cheque pertaining to the same

Note:
It is agreed that the Policyholder/Claimant will intimate in writing to HDFC Ergo Health. about any change in bank account details.
In an event Insured person bears expenses for treatment, please provide account details of Insured Persons in the above format along with proof of incurring such expenses.

DETAILS OF BILLS ENCLOSED: Section D

No	Bill No.	Bill Date	Bill Amount	Remarks
1	31326/2021	06-Nov-2021	500	Consultant Charges

DECLARATION BY THE INSURED: Section F

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 / 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.

Date: ..... Place: ..... Signature of the insured:

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