

HCL Technologies Ltd

OPD CLAIM SUMMARY FORM

EMPLOYEE DETAILS		MEDICAL CYCLE: 2023-24		
Claim No. : 1066241	No. of Claim Entries : 1	Total Claim : 110.00	Status : Submitted	
Name : Manish Kumar Sinha		EmpCode : 52018677	Band : E3	DOJ : 29 Nov 2021
Email ID : MANISHKUMAR_SINHA@HCLTECH.COM		Landline/Mobile : 8910205855		PayRollAreaCode : NG
Payee Name : Manish Kumar Sinha		Bank Name : ICICI BANK LTD		
IFSC Code : ICIC0000165		Account No. : 016505002863		

#	Name of Patient	Name of Chemist	Name of Doctor	Relationship	Age	Bill No	Preventive Health Check up	Medicine	Spectacles	Dental	Hearing Aid	Total Amount
1	Manish Kumar Sinha			Self	36		0.00	110.00	0.00	0.00	0.00	110.00
Total Claim Amount												110.00

This is to confirm that the below given items as checked are being provided from my end and they are genuine and correct as per my understanding.

Bills are pre-Numbered cash paid receipt	<input checked="" type="checkbox"/>
Cash memos from the Hospital / Chemist(s), supported by the Doctor's advice	
A. Doctor's advice is dated	<input checked="" type="checkbox"/>
B. Bills are dated	<input checked="" type="checkbox"/>
C. Breakup of bills is submitted	<input checked="" type="checkbox"/>
D. All tests Report/Investigation reports/X-ray are enclosed	<input checked="" type="checkbox"/>
E. Attending Doctor's / Consultant's / Specialist's / Anesthetist's bill and receipt and certificate regarding diagnosis, whichever is prescribed & thereby expenses incurred	<input checked="" type="checkbox"/>

CLAIM HISTORY			
Date	Status	Name	Remarks
05-Jun-2024	Submitted	Manish Kumar Sinha	please approve

Declaration

I hereby agree, affirm and declare that:

1. The statements/information given/stated by me/us in this claim form are true, correct and complete.
2. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.
3. If I have given/made any false or fraudulent statement /information /Documents, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I shall not be entitled to all/any rights to recover there under in respect

of any or all claims, past, present or future. Further, I am aware that submission of fraudulent claims can lead to disciplinary action under the Company policies up to and including termination.

4. The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.
5. I have read and understood the indicative list of Over the Counter Drugs.
6. Non Medical items are not payable under the policy.
7. I have read and understood that treatment for Cosmetic/Acne /Alopecia (Hair fall treatment)/ Malasma /hypo pigmentation / Infertility & Contraception related treatment/ HIV related Problem / Congenital External diseases is not payable.

Claims should be dropped in ES drop box with SAP Code, name and claim type written on the cover.

Place:

Date: Jun 05, 2024

Signature of Insured Employee

Important:

Since it is a pre-requisite for admission of claims under the policy that the Hospital / Nursing Home / Clinic where the Insured Person was admitted, is registered with Local Authorities, it is necessary for the claimant to ensure that the Hospital / Nursing Home / Clinic indicates the same on the Bill-cum-Receipt issued by them.