HCL TECHNOLOGIES LTD
OPD TREATMENT CLAIM SUMMARY FORM

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MEDICAL CYCLE: 2024-25

EMPLOYEE DETAILS			
Claim No. : 1268500	**No. of Claim Entries :** 1	**Total Claim :** ₹ 2300.00	**Status :** Submitted
Name : Manish Kumar Sinha	**EmpCode :** 52018677	**Band :** E3	
DOJ : 29-Nov-2021	**Email ID :** MANISHKUMAR_SINHA@HCLTECH.COM	**Landline/Mobile :** 8910205855	**PayRollAreaCode :** LK
Payee Name : Manish Kumar Sinha	**Bank Name :** ICICI BANK LTD	**IFSC Code :** ICIC0000165	**Account No. :** 016505002863

PATIENT'S DETAILS		
Name : Manish Kumar Sinha	**Relation with the Employee :** Self	**Age :** 37

CLAIM DETAILS	
Name of Doctor : Dr Vipin Kumar	**Illness :** OPD

#	Description	Amount	Claimed(Y/N)	Remarks
1	Room Charges for patient	₹ 0.00		
2	Room Charges for Attendant/Guests	₹ 0.00		
3	Test(s) /X-Charges	₹ 0.00		
4	Medicine Expenses	₹ 0.00		
5	Doctor's Fee	₹ 0.00		
6	Operation Theater Charges	₹ 0.00		
7	Surgery Charges	₹ 0.00		
8	Nursing Charges	₹ 0.00		
9	Any Other Charges(give brief details)	₹ 2300.00		
	Total Claim Amount	**₹ 2300.00**		

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	☑
Cash memos from the Hospital / Chemist(s), supported by the Doctors advice	☑
Doctors advice is dated	☑
Bills are dated	☑
Breakup of bills is submitted	☑
All tests Report/Investigation reports/X-ray are enclosed	☐

Attending Doctor’s / Consultant’s / Specialist’s / Anesthetist’s bill and receipt and certificate regarding diagnosis, whichever is prescribed & thereby expenses incurred	☑

CLAIM HISTORY			
Date	**Status**	**Name**	**Remarks**
20-Apr-2025	Submitted	Manish Kumar Sinha	I had chest pain. So doctor consultation and tests were advised.

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.

Please note that before dropping the claim, you have to enter claim information in the medical register which is kept on the medical claim drop box.

Place:
Date: 20-Apr-2025 **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.

AUTHORIZATION LETTER TO VIDAL HEALTH TPA PVT. LTD.

To

The Medical Superintendent

Sub: Request to verify /obtain copies of the Medical Records

I have undergone treatment for ----------

From---------- to---------- in your hospital / Clinic under

I consent & authorize my insurer (New India Assurance Co. Ltd) and it TPA Vidal Health TPA Pvt Ltd., to seek necessary medical information from the hospital / Medical Practitioner with regards to the settlement of this Medical claims.

Pls. provide the necessary help and inputs required for the same information/records required by the insurance. I have no objection whatsoever in this regard.

Thanking you,

Signature of the Patient:
Name of Patient:

Signature of the Employee:
Name of Employee:

Place:

Date: