<p id="decText"padding-top: 20px;">

CLAIM FORM - PART A' to 'CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED BY THE INSURED

Z0016176188

DETAILS OF PRIMARY INSURED:

Policy No.:	**590000/48/2024/951**	Sl. No/ Certificate no.			
Company/ TPA ID No:	**L AND T INFOTECH LIMITED**				
Name:	**MOHD TABISH**	EmpID:	**10705221**	MAID:	**5093871320**
Address:					
City:	**[CITY]**	State:	**[STATE]**		
Pin Code:	**[PINCODE]**	Phone No:	**9911115524**		
Email ID:	**MOHD.TABISH@LNTINFOTECH.COM**				

DETAILS OF INSURANCE HISTORY:

Currently covered by any other Mediclaim / Health Insurance:	☐ Yes ☐ No	Date of commencement of first Insurance without break:			
If yes, company name:	**L AND T INFOTECH LIMITED**	Policy No.:	**590000/48/2024/951**		
Sum insured (Rs.):		Have you been hospitalized in the last four years since inception of the contract?	☐ Yes ☐ No	Date:	
Diagnosis:		Previously covered by any other Mediclaim /Health insurance:	☐ Yes ☐ No		

DETAILS OF INSURED PERSON HOSPITALIZED:

Name:	**UMME KULSUM**	Gender:	☐ Male ☑ Female
Age years:	**28**	Date of Birth:	
Relationship to Primary insured:	☐ **SELF** ☑ **SPOUSE** ☐ **CHILD** ☐ **FATHER** ☐ **MOTHER** ☐ **OTHER(PLEASE SPECIFY)**		
Occupation:	☐ **SERVICE** ☐ **SELF EMPLOYED** ☐ **HOME MAKER** ☐ **STUDENT** ☐ **RETIRED** ☐ **OTHER(PLEASE SPECIFY)**		
Address(if diffrent from above):			
City:	**[CITY]**	State:	**[STATE]**
Pin Code:	**[PINCODE]**	Phone No:	**9911115524**
Email ID:	**MOHD.TABISH@LNTINFOTECH.COM**		

DETAILS OF HOSPITALIZATION:

Name of Hospital where amited:	**VEDANTA HOSPITAL,AZAMGARH,BILLARIYAGANJ ROAD, LACHHIRAMPUR,AZAMGARH,UTTAR PRADESH**				
Room Category occupied:	☐ **DAY CARE** ☐ **SINGLE OCCUPANCY** ☐ **TWIN SHARING** ☐ **3 OR MORE BEDS PER ROOM**				
Hospitalization due to:	☐ **INJURY** ☐ **ILLNESS** ☐ **MATERNITY**	Date of injury / Date Disease first detected /Date of Delivery:	**12-DEC-2023**		
Date of Admission:	**12-DEC-2023**	Time:		Date of Discharge:	**14-DEC-2023**
Time:					
If injury give cause:	☐ **SELF INFLICTED** ☐ **ROAD TRAFFIC ACCIDENT** ☐ **SUBSTANCE ABUSE / ALCOHOL CONSUMPTION**	If Medico legal:	☐ **YES** ☐ **NO**		
Reported to Police:	☐ **YES** ☐ **NO**	MLC Report & Police FIR attached:	☐ **YES** ☐ **NO**	System of Medicine:	

DETAILS OF CLAIM:

Pre -hospitalization expenses	INR	Hospitalization expenses	INR 830
Post-hospitalization expenses	INR	Health-Check up cost:	INR
Ambulance Charges:	INR	Others (code):	INR
Pre -hospitalization period:		Post -hospitalization period:	

Total: **INR 830**

b) Claim for Domiciliary Hospitalization: ☐ **YES** ☐ **NO (IF YES, PROVIDE DETAILS IN ANNEXURE)**

c) Details of Lump sum / cash benefit claimed:

Hospital Daily cash:	INR	Surgical Cash:	INR
Critical Illness benefit:	INR	Convalescence:	INR

Total: **INR 830**

Claim Documents Submitted - Check List:

☐ Claim form duly signed ☐ Copy of the claim intimation, if any ☐ Hospital Main Bill ☐ Hospital Break-up Bill ☐ Hospital Bill Payment Receipt

☐ Hospital Discharge Summary ☐ Pharmacy Bill ☐ Operation Theater Notes ☐ ECG

☐ Doctor?s request for investigation ☐ Investigation Reports (Including CT/ MRI / USG / HPE) ☐ Doctor?s Prescriptions ☐ Others

DETAILS OF BILLS ENCLOSED:

Sl No.	Bill No.	Date	Amount (Rs)	Remarks
1	1	12-Dec-2023	400	Doctor Consultation Fees
2	2	23-Dec-2023	339	Medicines post hospitalization
3	3	23-Dec-2023	91	stitch cut post hospitalization

DETAILS OF PRIMARY INSURED?S BANK ACCOUNT:

PAN:		Account Number:	**50100156434982**
Bank Name:	**HDFC BANK**	Branch:	**HDFC BANK LTD., MUNICIPAL NO 92-84 MOHALA NURPUR BUTAT, AZIZ NAGAR, MUBARAKPUR, DIST - AZAMGARH UTTAR PRADESH 276404**
Cheque / DD Payable details:		IFSC Code:	**HDFC0002662**

DECLARATION BY THE INSURED: I hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealent of any material fact with respect to questions asked in relation to this claim, my right to claim reimbrusement 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 except the pre/post-hospitalization claim, if any.

Date: ..... Place: .....

Signature of the Insured