

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

i. Pre-Hospitalisation Expenses: Rs. 13388/-
 iii. Post-Hospitalisation Expenses: Rs. 1500/-
 v. Ambulance Charges: Rs. -----

vii. Pre-Hospitalisation period: days 03

b) Claim for Domiciliary Hospitalisation: Yes No (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily Cash Rs. -----
 iii. Critical illness Benefit Rs. -----
 v. Pre/Post hospitalisation lump sum benefit Rs. -----

ii. Hospitalisation Expenses Rs. -----
 iv. Health checkup cost Rs. -----
 vi. Others (code) Rs. -----
 Total Rs. 14888/-
 viii. Post Hospitalisation period: days 07

SECTION E

Claim Documents Submitted – Check List

- | | | |
|--|--|---|
| <input checked="" type="checkbox"/> Claim Form Duly Signed | <input type="checkbox"/> Copy of claim intimation if any | <input type="checkbox"/> Original Hospital Main Bill |
| <input type="checkbox"/> Original Hospital Breakup Bill | <input checked="" type="checkbox"/> Original Hospital Bill Payment Receipt | <input checked="" type="checkbox"/> Original Hospital Discharge Summary/Pharmacy Bill |
| <input type="checkbox"/> Operation Theater Notes | <input type="checkbox"/> ECG | <input checked="" type="checkbox"/> Original Doctor's Prescriptions |
| <input checked="" type="checkbox"/> Original Doctors request for investigation reports (including CT/MRI/USG/HPE) | <input type="checkbox"/> Others | |
| <input checked="" type="checkbox"/> Cancelled blank cheque leaf with payee name printed. If name of the payee is not printed on the cheque leaf please attach copy of the first page of the bank passbook. | | |

DETAILS OF BILLS ENCLOSED

Sr.No	Bill No	Date	Issued by	Towards	Amount (Rs)
1	BLCS464975	170921	BLK MAX	Hospitalisation Main Bill	13388/-
2	BLCS464958	170921	-do-	Pre-Hospitalisation Bills: Nos	13388/-
3	BLCS464976	170921	-do-	Post-Hospitalisation Bills: Nos 01	1500/-
4	BLCS464966	170921	-do-	Pharmacy Bills	
5	BLCS461484	280921	-do-		
6					
7					
8					
9					
10					

SECTION F

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) Name of the Account Holder (As per Bank Account): MOVINUDDIN WAZIRUDDIN

b) Account no (As appearing in the cheque book): 50100016318806

c) Bank Name: HDFC BANK

d) Branch Name & Address: G R FLR INDUSTRY HOUSE OPP RAMON HOUSE 159 HT PAREKH MARG, CHURCHGATE MUMBAI - 400020 MAHARASHTRA

e) Account Type : Saving Current Cash Credit

g) IFSC Code: HDFC0000501

f) MICR No. 400240003

i) Cheque / DD Payable Details: 000011

h) PAN: BFFPM0722L

SECTION G

DECLARATION

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 Bajaj Allianz General Insurance Company Limited, 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.

Moynuddin.

SECTION H

Date: 30/10/2021 Place: DELHI

Signature of the Insured