Bajaj Allianz General Insurance Company Limited.
Regd. & Head Office : GE Plaza, Airport Road, Yerawada, Pune 411 006
Email id:-customercare@bajajallianz.co.in
Toll free no:1800-209-5858
020-30305858

(To be filled in block letters)

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT – PART A

TO BE FILLED IN BY THE INSURED
The issue of this form is not to be taken as an admission of liability

SECTION A

DETAILS OF PRIMARY INSURED

a) Policy No: b) Sl. No/Certificate No:
c) Company TPA ID No: d) Customer ID:
e) Company Name: f) Employee No:
g) Name:
h) Address:
City: State: Pin Code:
Phone No: Email ID:

SECTION B

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim / Health Insurance Yes No
b) date of commencement of first insurance without break
c) If yes, company name: Policy No:
Sum Insured (Rs.):
d) Have you been hospitalized in the last four years since inception of the contract? Yes No Date: D D M M Y Y Y Y
Diagnosis
e) Previously covered by any other Mediclaim / Health Insurance: Yes No
f) If yes, Company Name

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name of the Patient:
b) Health ID card no of the Patient:
c) Gender: Male Female d) Age: years months e) Date of Birth D D M M Y Y Y Y
f) Relationship of Primary insured: Self Spouse Child Father Mother Other (Please Specify)
g) Occupation: Service Self Employed Homemaker Student Retired Other (Please Specify)
h) Address (if different from above)
City: State: Pin Code:
I) Phone No: J) Email ID:

SECTION D

DETAILS OF HOSPITALIZATION

a) Name of Hospital where Admitted:
b) Room Category occupied: Day Care Single occupancy Twin sharing 3 or more beds per room
c) Hospitalisation due to: Injury Illness Maternity
d) Date of Injury/Date Disease first detected/Date of Delivery: D D M M Y Y Y Y
e) Date of admission D D M M Y Y Y Y f) Time: H H : M M g) Date of Discharge D D M M Y Y Y Y h)Time: H H M M
I) Name of treating doctor Diagnosis
j) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse /Alcohol Consumption
i) If Medico legal: Yes No ii) Reported to police: Yes No
iii) MLC report and Police FIR attached: Yes No j) System of Medicine

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

I. Pre-Hospitalisation Expenses:	Rs.	ii. Hospitalisation Expenses	Rs.
iii. Post-Hospitalisation Expenses:	Rs.	iv. Health checkup cost	Rs.
v. Ambulance Charges:	Rs.	vi. Others (code)	Rs.
		Total	Rs.
vii. Pre-Hospitalisation period:	days	viii. Post Hospitalisation period:	days

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.	ii. Surgical Cash	Rs.
iii. Critical illness Benefit	Rs.	iv. Convalescence	Rs.
v. Pre/Post hospitalisation lump sum benefit	Rs.	vi. Others	Rs.
		Total	Rs.

Claim Documents Submitted – Check List

- ☐ Claim Form Duly Signed
- ☐ Copy of claim intimation if any
- ☐ Original Hospital Main Bill
- ☐ Original Hospital Breakup Bill
- ☐ Original Hospital Bill Payment Receipt
- ☐ Original Hospital Discharge SummaryPharmacy Bill
- ☐ Operation Theater Notes
- ☐ ECG
- ☐ Original Doctor's Prescriptions
- ☐ Original Doctors request for investigation reports (including CT/MRI/USG/HPE)
- ☐ Others
- ☐ 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		D D M M Y Y		Hospitalisation Main Bill	
2		D D M M Y Y		Pre-Hospitalisation Bills:__Nos	
3		D D M M Y Y		Post-Hospitalisation Bills:__Nos	
4		D D M M Y Y		Pharmacy Bills	
5		D D M M Y Y			
6		D D M M Y Y			
7		D D M M Y Y			
8		D D M M Y Y			
9		D D M M Y Y			
10		D D M M Y Y			

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

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

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

c) Bank Name :_____

d) Branch Name & Address:_____:

e) Account Type : Saving ☐ Current ☐ Cash Credit ☐

f) MICR No. ☐☐☐☐☐☐☐☐☐☐☐☐ g)IFSC Code: ☐☐☐☐☐☐☐☐☐☐☐

h) PAN: ☐☐☐☐☐☐☐☐☐☐ i) Cheque / DD Payable Details: ☐

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 ha s 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: D D M M Y Y Y Y Place: _____

Signature of the Insured

SECTION E

SECTION F

SECTION G

SECTION H

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)		
DATA ELEMENT	DESCRIPTION	FORMAT
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No	License number a s allotted by IRDA and printed in TPA documents.
g) Name	Enter the full name of the policyholder	Surname, First name, Middle name
h) Address	Enter the full postal address	Include Street, City and Pin Code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance?	Tick Yes or No
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name Policy No. Sum Insured	Enter the full name of the insurance company Enter the policy number Enter the total sum insured a s per the policy	Name of the organization in full As allotted by the insurance company In rupees
d) Have you been Hospitalized in the last four years since inception of the contract? Date Diagnosis	Indicate whether hospitalized in the last four years Enter the date of hospitalization Enter the diagnosis details	Tick Yes or No Use dd-mm-yy format Open Text
e) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name of the Patient	Enter the full name of the patient	Surname, First name, Middle name
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
f) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
g) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
h) Address	Enter the full postal address	Include Street, City and Pin Code
i) Phone No	Enter the phone number of patient	Include STD code with telephon number
j) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time i) If Injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached	Enter time of discharge indicate cause of injury indicate whether injury is medico legal indicate whether police report was filed indicate whether MLC report and Police FIR attached	Use hh:mm format Tick the right option Tick Yes or No Tick Yes or No Tick Yes or No
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the amount claimed a s treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
d) Claim Documents Submitted -Check List	Indicate which supporting documents are submitted	Tick the right option
Indicate which bills are enclosed with the amounts in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
i) Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization in full
g) IFSC Code	Enter the IFSC code of the bank branch	FSC code of the bank branch in full
h) PAN	Enter the permanent account number	As allotted by the Income Tax department
SECTION H - DECLARATION BY THE INSURED Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		