MAX Bupa
HEALTH INSURANCE

Claim Form

CLAIM FORM
(The issue of this Form is not to be taken as an admission of liability)

PART A
TO BE FILLED IN BY THE INSURED (TO BE FILLED IN BLOCK LETTERS)

Do You Know
* Non-submission of original bills and receipts is the main reason for delay in claim settlements. Please provide the originals
* Provide your bank details for direct/ Electronic Fund Transfer (EFT) for faster claim settlement. Refer Part A - Section G
* To receive updates on your claim status, please provide your mobile no. & E-mail ID
* You can check your claim status at: www.maxbupa.com → Claims → Claims status → Login to check status

SECTION A - DETAILS OF PRIMARY INSURED

a) Policy No. : b) SI. No/ Certificate No :
c) Company/ TPA ID No :
d) Name : NAVEEN KUMAR HT
e) Address : #1803 7CROSS SUMANGALA NIVASA
HALLAHALLI MANDYA
City : MANDYA State : KARNATAKA
Pin Code : 571401 Phone No. 9739111713 Email ID : NAVEENHT@GMAIL.COM

SECTION B - DETAILS OF INSURANCE HISTORY

a) Currently covered by any other mediclaim health insurance Yes ☐ / No ☑
b) Date of commencement of first insurance for the person (without break) : (DD/MM/YYYY) :
c) If Yes, Company Name
Policy No. : Sum Insured :
d) Have you been hospitalized in the last four years since inception of the contract? Yes ☐ / No ☑ (DD/MM/YYYY) :
Diagnosis : e) Previously covered by any other Mediclaim/Health insurance Yes ☐ / No ☑
f) If Yes, Company Name :

SECTION C - DETAILS OF THE INSURED PERSON HOSPITALISED :

a) Name : SUMANGALA S
b) Relationship : Self ☐ / Spouse ☐ / Child ☐ / Father ☐ / Mother ☐ / Other ☐ (Please Specify) :
c) Date of Birth : 01/11/1952 d) Age (YY/MM) : 68 01 e) Gender : Male ☐ / Female ☑
f) Address : #1803 7CROSS SUMANGALA NIVASA
HALLAHALLI MANDYA
City : MANDYA State : KARNATAKA
Pin Code : 571401 Phone No. : 9739111713 Email ID : NAVEENHT@GMAIL.COM
g) Occupation : Service ☐ / Self employed ☑ / Homemaker ☐ / Student ☐ / Retired ☐ / Others (Please Specify) :

SECTION D - DETAILS OF HOSPITALISATION :

a) Name of the Hospital where admitted : SUSHRUTHA EYE HOSPITAL
b) Room Category occupied : Day care ☐ / Single occupancy ☐ / Twin sharing ☐ / 3 or more ☐ beds per room
c) Hospitalisation due to Illness ☐/ Injury ☐/ Maternity ☐ : Details : EYE OPERATION
d) Date of Injury/ Date of disease first detected/ Date of delivery (DD/MM/YYYY) :
e) Date of admission : (DD/MM/YYYY) : 25/07/2022 f) Time : (HH/MM) : 07 00
g) Date of discharge : (DD/MM/YYYY) : 26/07/2022 h) Time : (HH/MM) : 19 00
i) 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, & Police FIR attached? Yes ☐ / No ☐
j) System of medicine : Allopathic ☐ / Other systems of medicine ☐

SECTION E - DETAILS OF CLAIM :

a) Details of the treatment expenses claimed :
i) Pre-hospitalisation Expenses Rs. 2750 ii) Hospitalisation Expenses Rs. 27000
iii) Post-hospitalisation Expenses Rs. 5199 iv) Health-Check up Cost Rs. 4749

Please dispatch your claim document to: Max Bupa Corporate Office: Bloc B1/1-2, Mohan Cooperative Industrial Estate, Mathura Road, New Delhi -110044.