CLAIM FORM FOR HEALTH INSURANCE POLICIES OF THE NEW INDIA ASSURANCE CO LTD - PART A

TO BE FILLED IN BY THE INSURED

[illegible]

SECTION A

DETAILS OF PRIMARY INSURED

a) Policy No: 78070034280100000021

c) Name: CHITHAMBARANATHANU M

d) Address: 6/7, 10TH CROSS STREET, HINDU COLONY, NANGANALLUR

City: CHENNAI State: TAMILNADU

Pin Code: 600061 Phone No: 9841403597 Email ID: chithambaranathanu.@[illegible]

SECTION B

DETAILS OF INSURANCE HISTORY

[illegible] 07 07 16

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name: THIRUNEELAKANDAPERUMAL

b) Gender: Male ✓ c) Age: Years 69 Months 04 d) Date of Birth: 02 03 52

e) Relationship to Primary Insured: Father ✓

SECTION D

DETAILS OF HOSPITALIZATION

a) Name of Hospital where Admitted: SUBAM SPECIALITY HOSPITAL

b) Room Category occupied: Single occupancy ✓

c) Hospitalization due to: Illness ✓ d) Date of Injury / Date Disease first detected / Date of Delivery: 05 05 21

e) Date of Admission: 04 06 21 f) Time: 11 02 g) Date of Discharge: 07 06 21 h) Time: 10 20

SECTION E

DETAILS OF CLAIM

Claim Documents Submitted Check List

Hospitalization Expenses: Rs. 100524

Total: Rs. 100524

SECTION F

DETAILS OF BILLS ENCLOSED

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1				Hospital Main Bill	100524
2				Pre-hospitalization Bills: __ Nos	
3				Post-hospitalization Bills: __ Nos	
4				Pharmacy Bills	13524
5					
6					
7					
8					
9					
10					

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

A/C 000701151051

c) Bank Name and Branch: ICICI BANK CHINMAYA NAGAR ROAD CHENNAI

IFSC Code: ICIC0000001

(IMPORTANT PLEASE TURN OVER)

DECLARATION BY THE INSURED

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 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 1 4 / 0 7 / 2 1 Place NAGERCOIL Signature of the Insured [signature]

SECTION H

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)		
DATA ELEMENT	DESCRIPTION	FORMAT
	SECTION A - DETAILS OF PRIMARY INSURED	
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) Sl. 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 as allotted by IRDA and printed in TPA documents
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) 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	Enter the full name of the insurance company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	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	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Phone No.	Enter the phone number of patient	Include STD code with telephone number
i) 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	Enter time of discharge	Use hh-mm format
i) If Injury give cause	Indicate cause of injury	Tick the right option
If Medico-legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	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 as 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
	SECTION F - DETAILS OF BILLS ENCLOSED	
Indicate which bills are enclosed with the amounts in rupees		
	SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
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
d) 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
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
	SECTION H - DECLARATION BY THE INSURED	
Read declaration carefully and mention date (in dd-mm-yy format), place (open text) and sign		

CLAIM FORM FOR THE NEW INDIA ASSURANCE CO LTD: PART B
TO BE FILLED IN BY THE HOSPITAL

DETAILS OF HOSPITAL — SECTION A

SUBAM SPEZIALITY HOSPITAL

V S MUTHURAMALINGAM

MS ORTHO D.ORTHO — 49676 — 9942051031

DETAILS OF THE PATIENT ADMITTED — SECTION B

MR THIRUNELVELY PERUMAL

313512 — Male ✓ — 69

04 06 21 — 05 51 PM — 09 06 21 — 12 15 PM

Emergency ✓

Discharge to home ✓

DETAILS OF AILMENT DIAGNOSED (PRIMARY) — SECTION C

Diagnosis	Description
Primary Diagnosis	DM HT
Additional Diagnosis	COVID PNEUMONIA 30%
	HYPOTHYROIDISM

Procedure 1: CONSERVATIVE TREATMENT WITH LIFE SAVING DRUG

No ✓

CLAIM DOCUMENTS SUBMITTED - CHECK LIST — SECTION D

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON NETWORK HOSPITAL) — SECTION E

SUBAM SPECIALITY HOSPITAL
215 ASAMBU ROAD SMRV SCHOOL OPP
NAGERCOIL — TAMIL NADU
629001 — 9942051031 — TN 2204
AHUPMAEBER — 50 — Yes ✓ — Yes ✓

CATH LAB.

DECLARATION BY THE HOSPITAL — SECTION F

Date: 14 09 21
Place: NAGERCOIL

Signature and Seal of the Hospital Authority

Dr. V.S. MUTHU RAMALINGAM, D.Ortho, M.S.Ortho.
Reg. No: 49676
SUBAM SPECIALITY HOSPITAL
215, Opp. S.M.R.V. SCHOOL,
VADASERY, NAGERCOIL.

SUBAM SPECIALITY HOSPITAL VADASERY