PSRF0154190625IC1
Comp/Jun/Int/4264

HDFC Life
Sar utha ke jiyo!

HDFC LIFE - CANCER CARE CLAIM FORM

PART A

This form is to be filled by the Claimant in block letters. The issue of this form is not to be taken as an admission of liability. Primarily, the Policyholder will be the Claimant. In case of the death of the Policyholder, the Nominee will be the Claimant. If the Nominee is a minor, the Appointee will be the Claimant.

(A) DETAILS OF PRIMARY INSURED/CLAIMANT:

a. Policy No.: 101N106V04CC45892317 b. Sl No./Certificate No.: - - - - - - - - - - -

c. Company/TPA ID No.: -

d. Name: SHARMA RAHUL KUMAR

e. Address: FLAT-402 SHREE RESIDENCY MG ROAD

City: PUNE State: MAHARASHTRA

Pin Code: 411001 Phone No.: 9284307086 Email ID: rahul.sharma@gmail.com

(B) DETAILS OF INSURANCE HISTORY OF INSURED PERSON (If the space provided is inadequate, kindly attach annexures):

a. Currently covered by any other Mediclaim/Health/Critical Illness/Cancer Insurance: ☐ Yes ☑ No b. Date of commencement of first insurance without break: 15 07 18

c. If yes, company name: ______ Policy No.: ______

Sum Insured (INR): ______

d. Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☑ No Date: ______

Diagnosis: ______ Claim Status: ______

e. Previously covered by any other Mediclaim/Health/Critical Illness/Cancer Insurance ☐ Yes ☑ No f. If yes, company name: ______

Policy No.: ______ Sum Insured (INR): ______

Benefit Type: ☐ Mediclaim ☐ Critical Illness ☑ Cancer Insurance Date of commencement of first insurance without break: ______

Claim Status: ☐ Approved ☐ Rejected ☑ Pending

Other insurance Policy details or information which will enable us to process the claim: NO OTHER HEALTH OR CRITICAL ILLNESS POLICY HELD.

(C) DETAILS OF INSURED PERSON HOSPITALISED/DIAGNOSED WITH CANCER:

a. Name: SHARMA RAHUL KUMAR

b. Gender: Male ☑ Female ☐ c. Age (years): 46 d. Date of Birth: 12 03 79

e. Relationship with Primary Insured/Claimant: Self ☑ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ (Please Specify):

f. Occupation: Service ☑ Self-Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ (Please Specify):

fi. Nature of Work: IT PROJECT MANAGER

fii. Employer Name: INFOSYS LIMITED

fiii. Employer Address: HINJEWADI

fiv. Employer Contact Details: Phone No.: 9812391563[illegible] Email ID: hr.infosys@gmail.com

Mobile No.: 9285307581

g. Address (if different from above): SAME AS ABOVE

City: ______ State: ______

Pin Code: ______ Phone No.: ______ Email ID: ______

(D) DETAILS OF HOSPITALISATION/DIAGNOSIS:

a. Name of hospital where admitted/diagnosed: TATA MEMORIAL HOSPITAL

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 when disease first detected/Date of delivery: ______

e. Date of Admission: 25 09 24 f. Time: 10 30 g. Date of Discharge: 12 10 24 h. Time: 15 45

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: Allopathy k. Type of Cancer: Carcinoma in situ ☐ Early Stage Cancer ☐ Major Cancer ☑

(E) DETAILS OF CLAIM:

a. Details of the treatment expenses claimed:

i. Pre-Hospitalisation Expenses:	INR 45000	ii. Hospitalisation Expenses:	INR 680000
iii. Post-Hospitalisation Expenses:	INR 7500	iv. Health-Check up Cost:	INR
v. Ambulance Charges:	INR 6500	vi. Others (code):	INR
		Total	INR 806500
vii. Pre-Hospitalisation Period:	Days 05	vii. Pre-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:	INR 0	ii. Surgical Cash:	INR 0
iiii. Critical Illness Benefit:	INR 0	iv. Convalescence:	INR 0
v. Pre/Post Hospitalisation:		vi. Others (code):	INR 0
vii. Lump sum benefit:	INR 100000	Total	INR 1000000
viii. Cancer Care Benefit:	INR 100000		

d. Claim Documents Submitted - Check List:

☑ Claim Form Duly Signed	☑ Operation Theatre Notes	☑ Copy of the Claim Intimation, if any
☑ Hospital Discharge Summary: Present/Past Hospitalisations	☑ First Consultation and all Follow-up Consultation Notes	☑ Hospital Main Bill
☑ Investigation Reports/Plates (Xray/CT/MRI/USG/HPE)	☐ Employer Certificate: Leave Records, Sick-leave Certificate	☑ Hospital Break-up Bill
☑ Laboratory Test Reports	☑ Attested True Copy of Indoor Case Papers of the Hospital(s)	☑ Hospital Bill Payment Receipt
☑ Endoscopy/Colonoscopy Report	☑ Attending Physician's Statement	☑ Pharmacy Bill
☐ PAP Smear	☑ Attested Copy of Cancelled Personalised Cheque	☑ ECG
☐ Mammography	☑ Latest Bank Statement (not more than 3 months old)	☑ Doctor's Prescriptions
☑ Blood Test for Cancer Diagnosis (Tumor Marker)	☑ Copy of Pass Book (Indicating Account Number & IFSC Code)	☐ Others
☑ Clinical/Hospital Reports	☑ Doctor Consultation Referral Letter	
☑ Any Other Investigation Report	☑ Doctor's Request for Investigation	

(F) CLAIMED CONDITION DETAILS:

a. Final Diagnosis: INVASIVE ADENOCARCINOMA b. Date of Diagnosis: 22095

c. Date of First Consultation with Doctor: 20924 d. Nature and Duration of Complaints Necessitating Medical Attention: ABDOM

INAL PAIN, WEIGTT LOSS

e. Date when These Complaints First Became Evident: 08824

f. Site of Tumour: ASCENDING COLON

(G) PAST HEALTH HISTORY OF LIFE ASSURED:

a. Any Other Illness/Surgery Prior to the Current Illness (If the space provided is inadequate, kindly attach annexures): _____

_____ b. Date when this Illness was First Detected: ☐☐☐☐☐

c. Any Previous Malignancy or Pre-Malignancy Condition(s) ☐ Yes ☑ No

d. If Yes, Please Provide Details: _____

_____