

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

i. Pre-Hospitalisation Expenses:	Rs.	<input type="text"/>	ii. Hospitalisation Expenses	Rs.	<input type="text"/>
iii. Post-Hospitalisation Expenses:	Rs.	<input type="text"/>	iv. Health checkup cost	Rs.	<input type="text"/>
v. Ambulance Charges:	Rs.	<input type="text"/>	vi. Others (code)	Rs.	<input type="text"/>
			Total	Rs.	<input type="text"/>
vii. Pre-Hospitalisation period:	days	<input type="text"/>	viii. Post Hospitalisation period:	days	<input type="text"/>

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.	<input type="text"/>	ii. Surgical Cash	Rs.	<input type="text"/>
iii. Critical illness Benefit	Rs.	<input type="text"/>	iv. Convalescence	Rs.	<input type="text"/>
v. Pre/Post hospitalisation lump sum benefit	Rs.	<input type="text"/>	vi. Others	Rs.	<input type="text"/>
			Total	Rs.	<input type="text"/>

Claim Documents Submitted – Check List

<input 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 type="checkbox"/> Original Hospital Bill Payment Receipt	<input type="checkbox"/> Original Hospital Discharge Summary/Pharmacy Bill
<input type="checkbox"/> Operation Theater Notes	<input type="checkbox"/> ECG	<input type="checkbox"/> Original Doctor's Prescriptions
<input type="checkbox"/> Original Doctors request for investigation reports (including CT/MRI/USG/HPE)	<input type="checkbox"/> Others	
<input 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)			
		D	D	M	M	Y	Y						
1									Hospitalisation Main Bill				
2									Pre-Hospitalisation Bills: __Nos				
3									Post-Hospitalisation Bills: __Nos				
4									Pharmacy Bills				
5													
6													
7													
8													
9													
10													

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 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: Place:

Signature of the Insured