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