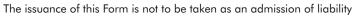
CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED

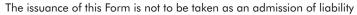




Toll Free No. 1800 266 3202

SECTION A - DETAILS	OF	PR	IM/	٩RY	'IN	ISL	JRE	D:	(То	be	fil	led	in	blo	ock	c le	tter	s)																	
a) Policy No:																b)	SI. 1	No/	′ Ce	rtific	cate	No	o:						Π						
c) Company/ TPA ID No:																																		_	
d) Name:																																			
e) Address:																																			
City:																	Stat	e:																	
Pin Code:												L	an	dlin	e (Wit	h S7	ΓD(Cod	e):[
Mobile No:																																			
[PLEASE PROVIDE ACTIVE EM	AIL	ID (JNL	Υ Α	S C	LAI/	NS (COI	RRES	SPO	ND	ENC	CE \	WILI	L BE	E SE	NT	ТО	THIS	EM	AIL	ID.]													
Email ID:			Ш																									L							
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SECTION B - DETAILS															H	7.												1				F	_		
a) Currently covered by any	oth	er /	Λed	icla	im /	/ H	ealt	h In	surc	anc	e:		Ye	es	L	\	40			b)		es,			Typ	e:		∫ Ir	ndiv	idu	al —	Ŀ	╧	Gro	oup
Company Name:			Ш						Щ							\perp						licy						<u>_</u>					<u>_</u>	<u></u>	Щ
c) Date of commencement of	of fi	rst Ir	ารบา	and	e w	vitho	out l	bre	ak:											d)	Su	m lı	ารบ	rec	l (R	s.):									
Have you been hospitalise	d ir	n the	e la	st f	our	ye	ars	sin	ce i	nce	ptic	on c	of th	he d	con	ntra	ct?			Ye	s			Νo											
Diagnosis:																																			
f) Previously covered by any	oth	er ۸	Λed ³	icla	im /	/ He	ealtl	h In	surc	ance	e:		Υ	'es		_ \	10																		
g) If yes, Company Name:																																			
SECTION C - DETAIL	S C)F I	NS	UR	ED	PE	RS¢	AC	I H	OS	PIT	ALI	SEI	D:																					
a) Name:														Π		Τ												П			\Box				
b) Gender:		М	ale	Ī		Fer	mal	е	C) Aç	ge:	Yec	ırs	Υ	Υ		N	lon	ths	Μ	Μ		d) [Date	e of	Biı	th:	D	D	M	M	Υ	Υ	Υ	Υ
e) Relationship to Primary In	sur	ed:		Sel	f [Spo	ous	e [Cł	nild	Γ	٦	Fa	_ the	r [Mot	her	T		Otl	ner	(Ple	eas	e Sı	peci	ify)			_		_	一
f) Address (if different fron					Ī		$\dot{\Box}$							Π	Π	Τ	Τ	T			٦	_			Ì		Γ.								一
City:							\Box							i	Sto	ate:	T		T									T			П				П
Pin Code:			Ħ										Pł	」 hon														Ħ		\equiv	П	\equiv			一
Email ID:			Ħ											Ī	Ī	T												Ħ	Ħ	F	П	F		Т	П
g) Occupation:		Se	rvic	e [Self	En	l olar	byec	<u>ا</u> ا	7	Hon	ner	nak	er	Ė	Stu	ıde	nt [\exists	Reti	red	Г	7) Oth	er l	Ple	ase	spe	ecif	v) [<u> </u>	Ħ
h) Name of Employer/ Firm's Name:																Ī	L						_						Ċ						
i) Address of the																																			
Employer/Firm:																																			
SECTION D - DETAIL	S C)F H	HO	SPI	TAL	_IS/	ATI	40	1 :																										
a) Name & Address of Hospital where Admitted:																																			
City:																	Sto	ıte:																	
Pin Code:								Lo	andı	ma	rk:																								
b) Room Category occupied:		Do	ау с	are		7 5	ing	jle d	occi	Jpa	ncy	, [7	Twi	n sl	har	ing		3	or	mo	re k	ed	ls p	er ı	00	m								
		01	ther	· (Pl	eas	e s	pec	ify)																											
c) Hospitalisation due to:		1	jury	_	_	llne			-	ate	rnit	ły																							
d) Date of Injury / Date Di	sec	ise f	first	de	_ tect	ed .	/ D	ate	of I	Del	iver	ry:		DI	D	М	M	Y	ΥI	<u> </u>	/														
e) Date of Admission:	D	D	Μ	Μ	Υ	Υ	1		ne:	_	Н	:	٨	M	a	ı) D	ate	of I	Disc	har	_ ge:	D	D	N	\ \ \	Υ	Y	7	h) T	ime	e: -	- -	- 1:	Μ	M
·	l) [) ate	of	De	live	ry:	D	D	М	M	Υ	Y) (_		la St		_						1							=		_	ᆿ
j) If injury give cause:	, -	,	lf-ir			1		Ro	oad	Tra	ffic	Aco		•			-		anc	e Al	ous	e /	Alc	oh	ol (Con	sun	npti	on						
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					-		سا ماندر	ı	R at	tac	J	_		Ye] No				┙.		_												
k) System of Medicine:		<u>-</u>		ک کرا ہ										T	Γ	$\frac{L}{L}$	J,	- 									1	Г		Г	П	Г	Г	Г	

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED





C	FCT	E	DETAIL	SOF	CLAIM

٠.١		ما:سده۱	-f +h	-46	treatment		ام مونور	
n	1 .)etails	of the	other	treatment	eynenses	claimed	

S.N.	Cover Name	Amount (in Rs)	S.N.	Cover Name	Amount (in Rs)
	Pre Hospitalization Expenses			Green channel benefit claim against Health wearable device	
	Post Hospitalization Expenses			Compassionate Visit in case of CI	
	Ambulance Cover			Vaccination for new born	
	Organ Donor Expenses			Out-patient Cover	
	Green channel benefit claim against Non payable expenses			Air Ambulance	
	Worldwide emergency optional cover			Maternity benefit optional cover	

b)	Details	s of	Lump	sum /	cash	benefit	claimed	Į
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S.N.	Cover Name	Claimed	S.N.	Cover Name	Claimed
	Hospital Cash	Yes No		Companion Benefit	Yes No
	Loss of income benefit	Yes No		Convalescence Benefit	Yes No
	Enhanced Daily cash benefit	Yes No		Benefit under Critical Illness optional Cover, if opted	Yes No
	Home treatment additional daily Cash benefit Yes No			Benefit under Personal Accident optional Cover, if opted	Yes No
	Hospital cash optional cover	Yes No			
Amount	as not above sovers if claimed by you will be naid as not the test	ne and conditions of	the Poli	ev nlan	

Amount as per above covers, if claimed by you, will be paid as per the terms and conditions of the Policy plan.

Check List of Claim Documents to be submitted (In original)* - Please (\checkmark) tick relevant box

(For Flospilal Cash belieff, pholocopies of	of Hospital Cash benefit, photocopies of claim documents are acceptable)								
Claim Form duly filled and signed	Copy of the Claim Intimation, if any	Hospital Bill Payment receipt							
Hospital Main Bill	Hospital Break-up Bill	Doctor's request for investigation							
Hospital Discharge Summary	Pharmacy Bill	Operation Theatre Notes							
Investigation Reports (Including CT	Test report and prescription relating to first consultation for the Illness								
Doctor's prescription for medicines investigation done outside hospital	FIR / MLC in case of accident injury and English translation of the same if it is in any other language								
KYC document (Address proof, ID p	Original Death Summary (Wherever applicable)								
Cancelled cheque leaf of the bank primary insured (Mandatory)	Any Other								

SECTION F - DETAILS OF BILLS ENCLOSED:

SI. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1.				Hospital Main Bill	
2.				Pre-hospitalisation Bills: No	s
3.				Post-hospitalisation Bills: No	s
4.				Pharmacy Bills	
5.					
6.					
7.					
8.					
9.					
10.					

Note: If there are more bills, please attach additional sheets with this claim form giving the bill details in same format as below.

Hospital Main Bill Payment Receipts only

Receipt No.	Date	Amount (Rs)	Please (√) Tick Relevant Box
			Advance Receipt Final Receipt
			Advance Receipt Final Receipt
			Advance Receipt Final Receipt
			Advance Receipt Final Receipt

Note: Please attach separate sheet if necessary

[•] For new born baby cover, separate claim form to be filled & submitted. • For Fitness Reward points, please fill separate form "Fitness reward earning claim form" available on our website. • Benefits under Cumulative Bonus, Early joining Benefit, Restoration of Sum Insured will be provided automatically. You need not file a claim separately for these.

^{*}Please retain copy of complete set of claim documents for your records

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED



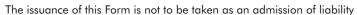
The issuance of this Form is not to be taken as an admission of liability IF THE CLAIM IS FOR ACCIDENTAL INJURIES, PLEASE PROVIDE DETAILS OF DATE, TIME AND CIRCUMSTANCES OF ACCIDENT EVENT AND OTHER DETAILS AS RELEVANT: Time: Date: Circumstances of Accident event and other details: SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT: PLEASE PROVIDE YOUR BANK DETAILS: (PLEASE ATTACH CANCELLED CHEQUE LEAF OF BANK ACCOUNT IN THE NAME OF PRIMARY INSURED WITHOUT FAIL) a) PAN: b) Account Number: c) Bank Name and Branch d) IFSC Code: e) Cheque/ DD Payable Details: SECTION H - 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, suppressed or concealed any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorise TPA / insurance company to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended the person for 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 pre/post hospitalization claim and for additional covers, if any. Date: Place: Signature of the Insured: Please send this duly filled and signed claim form to our TPA at below address: Family Health Plan Insurance TPA Limited Srinilaya - cyber spazio suite, 101,102,Ground Floor, Road No. 2, Banjara Hills, Hyderabad, Telangana 500034 GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured) DATA ELEMENT **DESCRIPTION FORMAT** SECTION A - DETAILS OF PRIMARY INSURED Enter the policy number a) Policy No. As allotted by the insurance company b) SI. No/ Certificate No. Enter the social insurance number or the certificate As allotted by the organisation number of social health insurance scheme 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 / Indicate whether currently covered by another Tick Yes or No Health Insurance? Mediclaim / Health Insurance Name of the organisation in full b) i. Company Name Enter the full name of the insurance company As allotted by the insurance company b) ii. Policy No. Enter the policy number c) Date of Commencement of first Insurance Enter the date of commencement of first Use dd-mm-yy format without break insurance d) Sum Insured Enter the total sum insured as per the policy In rupees Have you been Hospitalised in the last four years Indicate whether hospitalised in the last four years Tick Yes or No since inception of the contract? f) Date Enter the date of hospitalisation Use mm-yy format g) Diagnosis Enter the diagnosis details Open Text Indicate whether previously covered by another h) Previously Covered by any other Mediclaim/ Tick Yes or No Health Insurance? Mediclaim / Health Insurance

Name of the organisation in full

Enter the full name of the insurance company

i) Company Name

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED





GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)								
DATA ELEMENT	DESCRIPTION	FORMAT						
SECTIO	ON C - DETAILS OF INSURED PERSON HOSPITA	ALIZED						
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) Address	Enter the full postal address	Include Street, City and Pin Code						
Phone No.	Enter the phone number of patient	Include STD code with telephone number						
E-mail ID	Enter e-mail address of patient	Complete e-mail address						
g) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify						
i) Address of the Employer	Complete address of the employer of the Insured	Include Street, City and Pin Code						
SECTION D - DETAILS OF HOSPITALISATION FOR CLAIM BEING FILED								
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) Hospitalisation due to	Indicate reason of hospitalisation	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) In case of maternity								
I. Date of delivery	Enter date of delivery	Use dd-mm-yy format						
ii. Gravida Status	Enter Gravida Status	Use standard format						
j) If Injury give cause	Indicate cause of injury	Tick the right option						
i. If Medico Legal	Indicate whether injury is Medico Legal	Tick Yes or No						
ii. Reported to Police	Indicate whether police report was filed	Tick Yes or No						
iii. MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No						
k) 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 Hospitalisation	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 i	n rupees							
SECTION	G - DETAILS OF PRIMARY INSURED'S BANK AG	CCOUNT						
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) 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.								
nead decidration carefully and mention date (in dd	-mm-yy tormaij, piace (open text) and sign.							