



Bajaj Allianz Life Insurance Company Ltd.

HEALTHCARE CLAIM FORM

Applicable for:

- Hospital Cash Benefit
- Post-Hospitalization Benefit
- Surgical Benefit
- Partial and Total Permanent Disability Benefit-Supplement

* For Critical Illness & Death Claim under health care contact your nearest Bajaj Allianz Life Insurance Co. Ltd. Branch

Supporting documents required are:

- Medical Reports, including test report, treatment papers, etc
- Hospital discharge card
- Hospital Summary
- Hospital Bills (in Original)
- Surgeon's Reports (in Original)*

All payments shall be made according to terms and conditions of the policy.

The company retains right to call for further evidence needed to process the claim and to entertain or repudiate the claim.

Acceptance of forms does not amount to admission of claim.

* Mandatory for claiming surgical benefit

**** Please refer to the policy bond for the details.

Any one of the following must countersign this form. 1. An agent of Bajaj Allianz Life Insurance Co.Ltd. 2 Unit Manager of Bajaj Allianz Life Insurance Co LTD 3. An Advocate 4. A Bank Manager 5. A Block Development Officer 6. A Commissioner of Oaths 7. A Gazetted officer 8. President of Village Panchayat 9. A Magistrate 10. A Head postmaster 11. A Head master of a high school



Bajaj Allianz Life Insurance Company Ltd.

(I) HOSPITALISATION DETAILS

*** Mandatory for all kinds of benefits available under the plan**

Agency/Location/Agent's Code: _____

This printed form is issued on receipt of notice of the hospitalization/surgery/, and is no way an admission of liability.

Written notice of admission on which claim may be based must be given to the Company within fifteen days of hospitalization.

This form on which claim may be based must be submitted to the Company within fifteen days of discharge from hospital.

TO BE COMPLETED BY THE ASSURED / CLAIMANT

INSTRUCTION

1 POLICY NO	Claim Number: _____ (For office use only)
2 Life Assured details i. Name of Life Assured _____ ii. Address & Tel No. (if any) _____ iii. Age / Sex _____ iv. Occupation _____ v. Official address & Tel No. (if any) _____ vi. Date on which last attended to usual work _____	i. _____ ii. _____ _____ Tel _____ iii. Age _____ Sex: M <input type="checkbox"/> F <input type="checkbox"/> iv. _____ v. _____ _____ Tel: _____ vi. _____
3 Claimant's Details (If other than Life Assured) i. Name of claimant _____ ii. Relationship to Life assured _____ iii. Correspondence address & Tel No. _____	i. _____ ii. _____ iii. _____ _____ Tel: _____
4 If hospitalization was due to accident, please furnish details of accident? i. When did it occur? ii. Where did it occur? iii. How did it occur? iv. Nature and extent of injury v. FIR Number (copy to be enclosed)	i. _____ DD _____ MM _____ YY _____ am/pm ii. _____ iii. _____ iv. _____ v. _____
5 If hospitalization was due to other causes, please furnish i. Date of onset of illness _____ ii. Nature of illness / symptoms _____ iii. For how long have you (the Life Assured) been having the symptoms prior to first admission? iv. What was the diagnosis? v. Please mention the details of complaints with duration vi. Did you suffer from any other disease in past If Yes please give details	i. _____ ii. _____ iii. _____ iv. _____ v. _____ Duration _____ vi. _____ _____ _____

(II) HOSPITALISATION BENEFIT

6 Name of the doctor/s who had treated you (Life Assured) for the illness/ condition	Date of Consultation	Date of Admission (if any)
7. 1. Date of admission to hospital 2. Date of Discharge from Hospital 3. Total Number of Days in Hospital 4. Less 3 Days** 5. Number of Days for which Benefit would be paid*** 6. Please specify the amount of room charges in the hospital 7. Please specify the hospital cash amount as per the policy****		1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____
8. Please furnish us name and address of your (Life Assureds) usual attending doctor than above 		
9 Is the Life Assured presently insured for Hospitalization & Surgical benefits under any government law program, employer benefit, any health Scheme or any other insurance policy? <p style="text-align: right;">Yes/ No</p> <p>If so, please furnish details:</p> <p>1) Name of Company/Plan/scheme _____ _____</p> <p>2) Policy/ membership no.: _____</p>		



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(III) Post-Hospitalization Benefit

(Allowed for a maximum of 5 days in a policy year on the basis of recommendation of the hospital/ surgeon)

*** To be provided with attending doctor/ surgeon's certificate (Addendum-I)**

Number of days recommended: _____
Name of the doctor treated: _____
Name & Address of the hospital Where treatment taken: _____ _____ Tel: _____
Kind of follow-up treatment Advised: _____
Name of the doctor/ hospital who recommended: _____

(IV) Surgical Details

***To be submitted along with the original surgeon's report**

Name and address of Surgeon Who treated (the Life Assured) for this surgery	
Date of Consultation	
Date of Surgery	
Date of Admission	
Date of Discharge	
Amount of charges: 1. Surgeon's fee 2. Amount of Anesthetist fee 3. Amount of Operation Theater Charges	1. Rs. _____ 2. Rs. _____ 3. Rs. _____



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(V) TO BE COMPLETED FOR PERMANENT PARTIAL AND TOTAL DISABILITY BENEFIT ONLY

1. Give exact details of your occupation (describe your daily duties)
2. Describe the functional capability, specifying continuous length of time of weight on a typical workday Sitting _____ Standing _____ Walking _____ Lifting _____ Carrying _____ Bending _____ Nightshift _____
3. If disability is the result of an accident, state where and how it occurred
4. What aspect of the disability prevents you from following your occupation?
5. Date Last worked DD MM YY Are you still totally or partially disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you been able to perform any work since the event of disability?
7. When do you expect to return to work?
8. Do you intend to seek alternative employment?
9. Is there any aspect of the disability that you think will prevent you working in any occupation? If so, please give full details.
10. Have any of your blood/related relatives suffered from a similar or related illness? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please state the relationship of this relatives, nature of illness and date of illness)

DECLARATION AND AUTHORISATION BY LIFE ASSURED / CLAIMANT

I, _____, hereby declare that the information given in this claim form are true and that I/the Life Assured did not suffer from any pre-existing condition, except as may be disclosed during the application at the time this policy was taken up. I / Life Assured further declare that the current confinement to the hospital is not due to any causes which are stipulated in the exclusion clause of the policy. I further agree that in the event that I make or having in the past made any false or untrue statement and/ or suppressed and/ or concealed any material fact in respect of my / the Life Assured's health condition, the company shall absolutely forfeit my / Life Assured's right to compensation and reserve the right to recover any amounts paid earlier as a result thereof.

I, _____, having read and understood the contents hereby authorize any physician, hospital, clinic or insurance company or other organization, institutions, or persons that has any records or knowledge of me/Life Assured or



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my/Life Assured's health to disclose to BAJAJ ALLIANZ LIFE INSURANCE COMPANY LIMITED or its representative any and all such information and expressly waive on behalf of myself / the Life Assured or any person who shall have any claim or interest in any policy issued hereunder, all or any provision of law prohibiting any physician or surgeon from disclosing any information acquired while attending to me / the Life Assured in a professional capacity. This authorization shall irrevocably bind my successors and assigns and remain valid, notwithstanding my / the Life Assured's death or incapacity and a copy of this shall be as effective and valid as the original

Signature of Life Assured
Date
Address

Signature of Claimant
Date
Address

Signature of Witness
Name
Date
Address

Signature of Witness
Name
Date
Address



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ADDENDUM-I (Only for Post Hospitalization Benefit)

***To be filled in by the surgeon/hospital who had recommended follow-up treatment of Life Assured at home**

Number of days recommended: _____
Name of the doctor treated: _____
Name & Address of the hospital Where treatment taken: _____
_____ Tel: _____
Kind of follow-up treatment Advised: _____
Name of the doctor/ hospital who recommended: _____

Signature of Doctor/ In-charge at Hospital
Name of Hospital/ Doctor: _____
Registration number: _____
Address: _____

Tel: _____



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Claim Discharge form for Benefits under Health Care

Discharge of **Hospital Cash/Post-Hospitalization/ Surgical benefit/ Critical illness/Permanent Partial or Total Disability** under Policy No. _____ Dated _____

On the life of Shri / Smt _____
I / We _____ the life assured / policy-

Holder/nominee/assignee/legal representatives do hereby acknowledge receipt from Bajaj Allianz Life Insurance Co Ltd of the sum of

Rupees _____ (in words) _____

I / We discharge the company of all my / our claims and demands under the above mentioned policy:

Hospital cash amount Reimbursable (*, **, ***, *****)	Rs. _____
Post-Hospitalization amount reimbursable	Rs. _____
Surgical expenses amount	Rs. _____
Critical illness amount	Rs. _____
Permanent Partial/ Total Disability amount	Rs. _____
Others (if any)	Rs. _____
Gross claim amount	Rs. _____

LESS	
Unpaid installment of premiums due in the policy	Rs. _____
Late fee / Interest thereon	Rs. _____
X-charge	Rs. _____
Others	Rs. _____
Net claim amount	Rs. _____

Dated at _____ this _____ day of _____ 200____
(Place) (Date) (Month) (Year)

In the presence of

Revenue
Stamp of
1 rupee

Signature of witness

Full name
Designation Address & Seal

Signature of the claimant in full
across the revenue stamp

**** Please refer to the policy bond for this details.

CF00011

Note: Acceptance of forms does not amount to admission of claim.