

## **HOSPITALIZATION BENEFIT (Claimant's Statement)**

**Supporting Documents required are:**

- Medical Reports including investigation report, treatment papers etc
- Hospital Discharge Card
- Hospital Summary
- Original Hospital Bills

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.

\* The company reimburses for each full day an amount, which is lower of:  
75%( seventy five percent) of the room charge in the hospital  
The daily hospital cash amount

\*\* The first three days of hospitalization would not be paid for

\*\*\*The total number of days for which the hospital cash amount would be payable in a policy year would be restricted to 60 days, irrespective of the total number of hospitalization

\*\*\*\* 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



6 Name of the doctor/s who had treated you (Life Assured) for the illness/ condition	Date of Consultation	Date of Admission (if any)
<b>7.</b> 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. 75% of the room charges of 6 above 8. Please specify the hospital cash amount as per the policy****		1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____
<b>8. Please furnish us name and address of your (Life Assureds) usual attending doctor than above</b>  		
<b>9 Is the Life Assured presently insured for Hospitalization &amp; Surgical benefits under any government law program, employer benefit, any health Scheme or any other insurance policy?</b> <p style="text-align: right;">Yes/ No</p> <p><b>If so, please furnish details:</b></p> <p>1) Name of Company/Plan/scheme _____</p> <p>2) Policy/ membership no.: _____</p>		

**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



**Bajaj Allianz Life Insurance Company Ltd.**

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 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

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Signature of Life Assured  
Date  
Address

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Signature of Claimant  
Date  
Address

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Signature of Witness  
Name  
Date  
Address

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Signature of Witness  
Name  
Date  
Address