

# Claim Form

(For reimbursement of expenses)

Claim No.

Date

(For official use only)

Please provide the following information fully to enable us to process your claim appropriately.

1. Policy number (In full)

2. Name of the Policyholder (In whose name policy is issued)

### 3. Details of the Insured Person

a. Name of patient

b. Relationship with Policyholder  Self  Spouse  Son  Daughter c. Date of birth

d. Current address

City

District

State

Pin code

Phone No. STD code  Landline No.  Mobile No.

4. Nature of illness contracted or injury suffered

5. Date on which injury was sustained/disease or illness first detected

### 6. Details of the attending Doctor

a. Name

b. Address of the doctor

City

District

State

Pin code

c. Qualification

d. Phone No.

e. Registration number

7. **Details of the Hospital**

a. Name

b. Address of hospital

City  District

State  Pin code

Contact No  c. Registration No.

c. Inpatient bill no.

d. Date of admission

e. Date of discharge

8. **Type of Hospitalisation**  Planned  Emergency

9. **Details of expenses**

Expense Head	Amount (Rs.)
In Patient Treatment	
Pre-Hospitalisation	
Post-Hospitalisation	
Domiciliary Treatment	
Emergency Ambulance	
Medicine bills from outside hospital	
Diagnostic tests from outside hospital	
Out-patient expenses	
Other expenses not included above	
<b>Total Claimed Amount</b>	

10. **Have these expenses been paid by you?** Yes  No

11. **Number of document(s) submitted including this claim form**

12. **Please enclose the following documents**

- (i) Original bills, receipts and discharge certificate/card from the hospital/doctor.
- (ii) Original bills from chemists supported by proper prescription.
- (iii) Original investigation test reports and payment receipts.
- (iv) Original medical practitioner/doctor's referral letter advising hospitalisation.
- (v) Details of any other insurance policy that may respond to the claim.

13. **Are you presently covered under any other type of insurance (individual or group health insurance)?**  Yes  No

If yes, please give the details as follows:

Name of Insurance Company	Policy Number	Start Date	End Date	Sum Insured

The submission/receipt of this form does not amount to admission of any liability under the claim on the part of the insurers.

I/we hereby authorise Max Bupa Health Insurance Company Limited to transfer the claim amount payable under this claim to my bank account.

Account holder's name

Bank

Account No.

Branch

City

IFSC code

MICR code

Other payment option is cheque. Please tick if you want the payment to be made via cheque. The cheque will be sent to the policy holder's address when the claim is processed.

Please refer to the Max Bupa policy guide for detailed information of the benefits that you are eligible under your policy.

MICR Code: The MICR code can be found on the bottom of a cheque/cheque book. It appears after the cheque number.

IFSC Code: The IFSC code is listed on your cheque/cheque book. In case it is not listed, please request your bank for the same.

**Declaration:**

I declare and warrant that the information given above and the information that will be given in respect of this claim is correct and complete. I further agree and understand that if any false statement, or declaration is made or used in support of such claim, or if any fraudulent means or devices are used by the Insured Person to obtain any benefit under this Policy, then this Policy shall be void and all claims being processed shall be forfeited for all Insured Persons and all sums paid under this Policy shall be repaid to Us by all Insured Persons who shall be jointly liable for such repayment.

I further agree that all customers' personal information collected or held by Max Bupa will be used for processing the claims and analysis related to insurance/reinsurance business.

Date

\_\_\_\_\_  
Signature of the Claimant



**Max Bupa Health Insurance Company Limited**

Registered Office: Max House, 1 Dr. Jha Marg, Okhla, New Delhi - 110 020.

Corporate Office: D-1, 2nd Floor, Salcon Ras Vilas, District Centre, Saket, New Delhi-110 017.

Insurance is the subject matter of solicitation.

'Max', Max Logo, 'Bupa' and HEARTBEAT logo are trademarks of their respective owners and are being used by Max Bupa Health Insurance Company Limited under license.