CLAIM FORM FOR HOSPITALIZATION REIMBURSEMENT BENEFIT
FOR SECURE EARNINGS AND WELLNESS ADVANTAGE PLAN
CLAIM FORM – PART A

To be filled in by the Insured

The issue of this form is not to be taken as an admission of liability

(To be filled in block letters)

SECTION A – DETAILS OF PRIMARY INSURED

Policy no:

Company/TPA ID no:

Name:

Address:

City: State:

Pin code: Phone no.:

E-mail ID: _____

SECTION B – OTHER INSURANCE HISTORY

Policy No.	Company Name	Sum Assured	Status(active/lapsed/applied/matured)	Claim Status

SECTION C- DETAILS OF INSURED PERSON HOSPITALISED

a) Name:

b) Gender: Male ☐ Female ☐ c) Current Age: ☐☐☐☐ d) Date of Birth: ☐☐☐☐☐☐☐☐

e) Occupation: Service ☐ Self-employed ☐ Homemaker ☐ Student ☐ Retired Other ☐

Please specify:

f) Address (if different from above):

City: State:

Pin code: Phone no.:

E-mail ID: _____

SECTION D- DETAILS OF HOSPITALIZATION

a) Name of the hospital where admitted:

b) Room category occupied: ICU ☐ Non ICU ☐

c) Hospitalization due to: Illness ☐ Injury ☐ Maternity ☐

d) Date of Injury/Date of 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 of admission: H H : M M

g) Date of discharge: D D M M Y Y Y Y h) Time of discharge: H H : M M

i) 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 ☐

j) System of medicine: Allopathy/Homeopathy/Ayurveda/Unani/Naturopathy

SECTION E- DETAILS OF CLAIM

a) Details of the treatment expenses claimed

i) Hospitalization period:

Days ☐☐☐ ICU ☐☐ Non ICU ☐☐☐

b) Details of lumpsum/cash benefit claimed:

i) Hospital daily cash Rs. ☐☐☐☐☐☐☐

ii) Surgical cash Rs. ☐☐☐☐☐☐☐

iii) Critical illness benefit Rs. ☐☐☐☐☐☐☐

iv) Claim documents submitted-check list:

- ☐ Duly filled and signed claim form
- ☐ Copy of intimation letter, if any
- ☐ Hospital main bill
- ☐ hospital break up bill
- ☐ hospital bill payment receipt
- ☐ Hospital discharge summary
- ☐ Pharmacy bill
- ☐ Operation theater notes
- ☐ Doctor's request for investigation
- ☐ Doctor's prescription
- ☐ Allinvestigation reports including ECG,CT, MRI/USG/HPE)
- ☐ KYC of LA and/or Nominee (Personalized cancelled cheque, Passbook/PAN)

SECTION – G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN: ☐☐☐☐☐☐☐☐☐☐ b) Account number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c) Bank name/branch: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

d) Payable details: Cheque/DD: _____ e) IFSC code: ☐☐☐☐☐☐☐☐☐☐☐

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, 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 TPA/insurance company, to seek necessary medical information/documents from any hospital/Medical Practitioner who has attended on the person against whom this claim is made.

I voluntarily provide my consent to use my Aadhar to conduct identity check towards KYC compliance by MAX LIFE INSURANCE

Date: D D M M Y Y Y Y

Place: _____ Signature of insured:

MAX LIFE INSURANCE

GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy no.	Enter the policy number	
b) Company TPA ID no.	Enter the TPA ID no.	
c) Name	Enter the full name of the policyholder	<Surname, First name, Middle name>
d) Address	Enter the full postal address	
SECTION B - DETAILS OF INSURANCE HISTORY		
	Indicate whether currently covered by another Mediclaim / Health insurance	Yes ☐ No ☐
	Enter the date of commencement of first insurance	D D M M Y Y Y Y
e) Company name	Enter the full name of the insurance company	
Policy no.	Enter the policy number	
Sum insured	Enter the total sum insured as per the policy	
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	
b) Gender	Indicate gender of the patient	
c) Age	Enter completed age of the patient	
d) Date of Birth	Enter date of birth of patient	D D M M Y Y Y Y
e) Occupation	Indicate occupation of patient/LA	
f) Address	Enter the full postal address	
g) Phone no	Enter the phone number of patient/LA	
h) E-mail ID	Enter e-mail address of patient/LA	
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admitted	Enter the name of hospital	
b) Room category occupied	Indicate the room category occupied	
c) Hospitalization due to	Indicate reason of hospitalization	
d) Date of injury/Date of disease first detected/ Date of delivery	Enter the relevant date	D D M M Y Y Y Y
e) Date of admission	Enter date of admission	D D M M Y Y Y Y
f) Time	Enter time of admission	H H : M M
g) Date of discharge	Enter date of discharge	D D M M Y Y Y Y
h) Time	Enter time of discharge	H H : M M
i) If injury give cause	Indicate cause of injury	
If medico legal	Indicate whether injury is medico legal	Yes ☐ No ☐

Reported to police	Indicate whether police report was filed	Yes ☐ No ☐
	Indicate whether MLC report and police FIR attached	Yes ☐ No ☐
j) System of medicine	Enter the system of medicine followed in treating the patient	
SECTION E – DETAILS OF CLAIM		
a) details of treatment expenses	Enter the amount claimed as treatment expenses	
c) Details of lump sum/cash benefit claimed	Enter the amount claimed as lump sum/cash benefit	
d) Claim documents submitted-check list	Indicate which supporting documents are submitted	
Indicate which bills are enclosed with the amounts in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	
b) Account number	Enter the bank account number	
c) Bank name and branch	Enter the bank name along with the branch	
d) Cheque/DD payable details	Enter the name of the beneficiary the cheque/DD should be made out to	
e) IFSC code	Enter the IFSC code of the bank branch	

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CLAIM FORM FOR HOSPITALIZATION REIMBURSEMENT BENEFIT
FOR SECURE EARNINGS AND WELLNESS ADVANTAGE PLAN
CLAIM FORM – PART B
TO BE FILLED IN BY THE HOSPITAL

DETAILS OF HOSPITAL

a) Name of hospital:
b) Hospital ID:
c) Type of hospital: Network ☐ Non-network ☐ If non-network fill section E
d) Name of the treating doctor:
e) Qualification ☐ f) Registration no. with state code:
g) Phone no.:

DETAILS OF THE PATIENT ADMITTED

a) Name of the patient:
b) Registration no.: c) Gender: Male ☐ Female ☐
d) Age: Years ☐☐ Months ☐☐ e) Date of birth: D D M M Y Y Y Y
f) Date of admission: D D M M Y Y Y Y g) Time of admission: H H : M M
h) Date of discharge: D D M M Y Y Y Y i) Time of discharge: H H : M M
j) Type of admission emergency: ☐ Planned ☐ Day care ☐
k) If maternity: i) Date of delivery: D D M M Y Y Y Y ii) Gravida status: ☐☐☐☐
l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a) ICD 10 Codes	Description	b) ICD 10 PCS	Description
i) Primary diagnosis ☐☐☐☐☐☐☐☐		i. Procedure 1. ☐☐☐☐☐☐☐☐	
ii) Additional diagnosis ☐☐☐☐☐☐☐☐		ii. Procedure 2. ☐☐☐☐☐☐☐☐	
iii) Co-morbidities: ☐☐☐☐☐☐☐☐		iii. Procedure 3. ☐☐☐☐☐☐☐☐	
iv) Co-morbidities ☐☐☐☐☐☐☐☐		iv). Procedure 4.	

c) Present ailment is a complication of Pre-existing? YES ☐ NO ☐ If Yes, specify details ☐
f) Hospitalization due to injury: Yes ☐ No ☐
i) If Yes, give cause: Self-inflicted ☐ Road traffic accident ☐ Substance abuse/alcohol consumption ☐
ii) If Injury due to substance abuse/alcohol consumption, test conducted to establish this: Yes ☐ No ☐
(If yes, attach reports) iii) If Medico legal: Yes ☐ No ☐
iv) Reported to police: Yes ☐ No ☐ v) FIR no. ☐☐☐☐☐☐☐☐☐☐
vi) If not reported to police give reasons ☐

MAX LIFE INSURANCE

CLAIM DOCUMENTS SUBMITTED. CHECK LIST

- ☐ Claim form duly signed
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital discharge summary
- ☐ Operation theatre notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ All Investigation reports including (CT/MRI/USG/HPE/ECG etc.)
- ☐ Pharmacy bills
- ☐ KYC of LA/Nominee (personalized cancelled cheque/ passbook, PAN, Aadhar)

DETAILS IN CASE OF NON-NETWORK (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of hospital:

b) City: C) State:

d) Pin code: e) Phone no:

f) Registration no: g) PAN:

h) Number of inpatient beds i) Facilities available in the hospital: i) OT: Yes ☐ No ☐

ii) ICU: Yes ☐ No ☐ iii). Others

DECLARATION BY THE INSURED (PLEASE READ VERY CAREFULLY)

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, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA I insurance company; to seek necessary medical information I documents from any hospital/Medical Practitioner who has attended on the person against whom this claim is made. I voluntarily provide my consent to use my Aadhar to conduct identity check towards KYC compliance by MAX LIFE INSURANCE.

Date: D D M M Y Y Y Y

Place: _____

Signature of Insured:

DECLARATION BY THE HOSPITAL

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Date: D D M M Y Y Y Y

Place: _____

Signature of Insured:

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

In-patient treatment /day care procedures

- ☐ Duly filled and signed claim form.
- ☐ Photocopy of ID card/photocopy of current year policy.

- [ ] Copy of detailed discharge summary with date of admission & discharge, clinical history, past history/ procedure details/day care summary from the hospital.
- [ ] Copy of consolidated hospital bill with break up of each item, duly signed by the insured. Payment receipt of the hospital bill.
- [ ] Payment receipt of the hospital bill.
- [ ] First consultation letter and subsequent prescriptions.
- [ ] Copy of bills, copy of payment receipts and reports for investigation.
- [ ] Copy of medicine bills and receipts with corresponding prescriptions.
- [ ] Copy of invoice/sticker of implants/bills for Implants (viz. Stent/PHS mesh/IOL etc.) with payment receipts

Road traffic accident

In addition to the In-patient treatment documents:

- [ ] Copy of the First Information Report from police department/copy of the Medico-Legal certificate.

In Non Medico legal cases

- [ ] Treating doctor's certificate giving details of injuries (how, when and where injury sustained)

CUSTOMER IDENTIFICATION PROCEDURE (AS PER KYC NORMS OF IRDA)	
Please submit the following documents in case of claim amount exceeds Rs. 100,000	
Legal name and any other names used (Any one of the mentioned documents)	Passport/PAN card/voter's identity card/driving license/ letter from a recognized public authority or public servant verifying the identity and residence of the customer
Proof of residence (Any one of the mentioned documents)	Telephone bill/bank account statement/letter from any recognized public authority/electricity bill/ration card

NOTE: Please send the documents to TPA office on below address or email the documents to the email id given below:

TPA Name: **MD India Health Insurance TPA Pvt. Ltd.**
Address: **S. No. 46/1, E-space, A-2 Building, 2nd floor, Pune Nagar Road, Vadgaonsheri, Pune 411014.**
Email ID: **customercare@mdindia.com**
Toll Free No.: **1800 210 6862**
Website: **www.mdindiaonline.com**