Health Assurance Claim Form

Claim No. ______________________ Date: ______________________

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

1. Policy number (In full) / Customer Id ______________________

2. Details of the Insured Person
   a) Name of the patient: ______________________
   b) Relationship with the Proposer: Self, Spouse, Son, Daughter
   c) Current address: ______________________
    
     City ______________________ State ______________________
     Date of admission: ______________________ Time of admission __:__:
     Date of discharge: ______________________ Time of discharge __:__:

3. Cover being claimed for:
   a). CritiCare
      1. Cancer of Specified Severity
      2. Open Chest CAGB
      3. Coma of Specified Severity
      4. Stroke Resulting in Permanent Symptoms
      5. Permanent Paralysis of Limbs
      6. Multiple Sclerosis with Persisting Symptoms
      7. Fulminant Viral Hepatitis
      8. Aplastic Anemia
      9. Deafness
      10. Muscular Dystrophy
      11. First Heart Attack of Specified Severity
      12. Open Heart Replacement or Repair of Heart Valves
      13. Kidney Failure Requiring Regular Dialysis
      14. Major Organ/BoneMarrow Transplant
      15. Coma of Specified Severity
      16. Open Chest CAGB
      17. Permanent Paralysis of Limbs
      18. Multiple Sclerosis with Persisting Symptoms
      19. fulminant Viral Hepatitis
      20. Aplastic Anemia
      21. Deafness
      22. Muscular Dystrophy
   b). HospiCash
   c). AccidentCare
      i. Accident Death
      ii. Accident Permanent Total Disability
      iii. Accident Permanent Partial Disability
      iv. Temporary Total Disability
      v. Accident Hospitalization

4. Date on which injury was sustained /disease or illness first detected ______________________
5. Details of the attending doctor

Name of the doctor
Address of the doctor
City
Qualification
Registration No.

6. Details of the hospital

Hospital Name
Address of the hospital
City
State

Phone
Pin code
Registration No.

7. Date of admission

8. Details of claim

<table>
<thead>
<tr>
<th>Expense Head</th>
<th>Amount</th>
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<tbody>
<tr>
<td>1. CritiCare</td>
<td></td>
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<td>2. HospiCash</td>
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<tr>
<td>3. AccidentDeath</td>
<td></td>
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<tr>
<td>3a. Accident Permanent Total Disability</td>
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<tr>
<td>3c. Accident Permanent Partial Disability</td>
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<tr>
<td>3d. Children’s Education Allowance</td>
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<td>3e. Funeral Expenses</td>
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<td>3f. Accident Temporary Total Disability</td>
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<tr>
<td>3g. Accident Hospitalization</td>
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<tr>
<td><strong>Total Claimed Amount (A)</strong></td>
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</tbody>
</table>

If you have opted for CritiCare option 2, no separate claim form would be required. The amount due shall get credited into the account automatically.

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

10. Please enclose the following documents:

A. Accident Death
   a) Duly filled and signed claim form and KYC documents
   b) Copy of Death Certificate (issued by the office of Registrar of Births and Deaths)
   c) Copy of First Information Report (FIR) / Panchnama
   d) Copy of Medico Legal Certificate duly attested by the concerned hospital, if applicable
   e) Copy of Hospital Record, if applicable
   f) Copy of Post Mortem Report wherever applicable
B. Accident Permanent Total Disability
   a) Duly filled and signed claim form and KYC documents
   b) Hospital Discharge Summary (in original)/self attested copies if the originals are submitted with another insurer
   c) Final Hospital Bill (in original)/self attested copies if the originals are submitted with another insurer
   d) Medical consultations and investigations done from outside the hospital
   e) Certificate of Disability issued by a Medical Board duly constituted by the Central and/or the State Government
   f) Copy of First Information Report (FIR)/Panchnama if applicable
   g) Copy of Medico Legal Certificate duly attested by the concerned hospital, if applicable

C. Accident Permanent Partial Disability
   a) Duly filled and signed claim form and KYC documents
   b) Hospital Discharge Summary (in original)/self attested copies if the originals are submitted with another insurer
   c) Final Hospital Bill (in original)/self attested copies if the originals are submitted with another insurer
   d) Medical consultations and investigations done from outside the hospital
   e) Certificate of Disability issued by a Medical Board duly constituted by the Central and/or the State Government
   f) Copy of First Information Report (FIR)/Panchnama if applicable
   g) Copy of Medico Legal Certificate duly attested by the concerned hospital, if applicable

D. Accident Temporary Total Disability
   a) Duly filled and signed claim form and KYC documents
   b) Hospital Discharge Summary (in original)/self attested copies if the originals are submitted with another insurer
   c) Final Hospital Bill (in original)/self attested copies if the originals are submitted with another insurer
   d) Copy of First Information Report (FIR)/Panchnama/Inquest report if applicable
   e) Copy of Medico Legal Certificate duly attested by the concerned hospital if applicable
   f) Attendance record of employer/Certificate of employer confirming period of absence
   g) Disability certificate from treating doctor with seal and stamp
   h) Medical certificate and Fitness certificate with seal and stamp

E. Accident Hospitalization
   a) Duly filled and signed claim form and KYC documents
   b) Hospital Discharge Summary in original/self attested copies if the originals are submitted with another insurer, if applicable
   c) Final Hospital Bill in original/self attested copies if the originals are submitted with another insurer, if applicable
   d) Copy of First Information Report (FIR)/Panchnama/Inquest report if applicable
   e) Copy of Medico Legal Certificate duly attested by the concerned hospital if applicable
   f) Original bills with supporting prescriptions and reports for investigations done outside the hospital/copies attested by other insurer if the originals are submitted with them
   g) Original bills with supporting prescriptions for medicines purchased from outside the hospital/copies attested by other insurer if the originals are submitted with them
   h) Consultation notes and/or investigation reports from outside the hospital prior to hospitalization
   i) First consultation note and all medical record since onset of complaint
   j) Copy of First Information Report (FIR) (if CritiCare being claimed for is admissible in event of an Accident)
   k) Copy of Medico Legal Certificate (in case of accidental injury) if applicable
   l) Copy of Medico Legal Certificate (in case of accidental injury) if applicable

F. CritiCare
   a) Duly filled and signed claim form with KYC documents
   b) Hospital Discharge Summary in original/self attested copies if the originals are submitted with another insurer
   c) Final Hospital Bill in original/self attested copies if the originals are submitted with another insurer
   d) Consultation notes and/or investigation reports from outside the hospital prior to hospitalization
   e) Copy of First Information Report (FIR)/Panchnama (In case of accidental injury) if applicable
   f) Copy of Medico Legal Certificate (In case of accidental injury) if applicable

G. HospiCash
   a) Duly filled and signed claim form with KYC documents
   b) Hospital Discharge Summary in original/self attested copies if the originals are submitted with another insurer
   c) Final Hospital Bill in original/self attested copies if the originals are submitted with another insurer
   d) Consultation notes and/or investigation reports from outside the hospital prior to hospitalization
   e) Copy of First Information Report (FIR)/Panchnama (In case of accidental injury) if applicable
   f) Copy of Medico Legal Certificate (In case of accidental injury) if applicable

Note: 1. We may ask for additional documents if required for claim processing
2. No documents are to be provided for claiming Funeral Expenses and Children Education Expenses
11. Is Insured Person at present covered under any type of Health Insurance (Individual or Group)  
If yes, please give the details as follows:

<table>
<thead>
<tr>
<th>Name of Insurance Company</th>
<th>Policy No.</th>
<th>Application No.</th>
<th>Insured From (Date)</th>
<th>To (Date)</th>
<th>Sum Insured</th>
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<tbody>
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12. Is Insured Person at present covered under any Personal Accident cover (Individual or Group)  
If yes, please give the details as follows:

<table>
<thead>
<tr>
<th>Name of Insurance Company</th>
<th>Policy No.</th>
<th>Application No.</th>
<th>Insured From (Date)</th>
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The submission/receipt of this form does not amount to admission of any liability under the claim on the part of the insurers.

I hereby authorize Max Bupa Health Insurance Company Limited to transfer the claim amount payable under this claim to the following bank account.

Account holder’s name
Account No.  Branch
IFSC code
Bank
City

MICR code

Please tick if you want the payment to be made via cheque. The cheque will be sent to the policy holder’s address.

Please refer to the Max Bupa policy guide for detailed information of the benefits that Insured Person is eligible under the policy.

Note:
MICR Code: The MICR code can be found on the bottom of the 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 hereby 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 with respect to such claim or if any fraudulent act, means or devices are used to obtain benefit under this Policy then this policy shall be void and all claims being processed shall be forfeited for any/all Insured Persons and all sums paid under this policy shall be repaid to Us by the beneficiary under the Policy I further authorize any hospital, physician Insurance Company or Organization that has any records or knowledge of me or my health to furnish such information to Max Bupa Health Insurance Company Limited (“Max Bupa”) and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. A Photostat copy of this authorization shall be considered as effective and valid as the original.

I understand that if I and/or the member(s) fail to provide any information requested in this claim form, it may result in the inability of Max Bupa to accept or process this claim.

I understand that all Customer personal Information collected or held by Max Bupa will be used for processing the claims and analysis related to Insurance / Reinsurance business.

Date

Name and Signature of Claimant