United India Insurance Co Ltd

Registered & Head Office: **24, Whites Road Chennai-600014 India**.

HOSPITALISATION AND DOMICILIARY HOSPITALISATION BENEFIT POLICY

CLAIM FORM

Issuance of this form does not amount to admission of any liability of under the policy on the part of the insurers Please give the following information correctly and completely to enable us process your claim promptly.

All dates to be entered as Date / Month / Year

1. **Name of the Insured: M/S.HDFC BANK LTD**

- Name of the employee: _____
- Name of the patient:_____
- Employee Code. _____
- Patient's Relationship with the Employee :-
- Age of Patient:
- Occupation:
- Residential Address: _

_ _

_____

2. **Policy Number** : HDFC Bank Staff - **0204002820P100241219**

: HDFC Bank Officer - **0204002820P100241254**

Policy Period: 01 APRIL 2020 TO 31 MARCH 2021

3. E-Mail id: _____

4. Mobile No.: -

5. Diagnosis/ Ailment: -

6. Name & Address of the Hospital/Nursing Home/Clinic:

Pin Code State / U. Territory _____

(b) Date of Admission: - _____ Time _____

(c) Date of Discharge: - _____ Time _____

In support of the above claim, I enclose the following original documents (Please indicated by)

1 Bill (detail break up), Receipt and Discharge certificate / card from the Hospital.

2 Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.

3 Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests.

4 In case of road traffic accident kindly furnish FIR or MLC copy.

5 G.P.L.A. Certificate from doctor if not mentioned on discharge card for the claim of maternity.

6 Lens sticker / Invoice for the claim of Cataract Surgery.

Summary of expenses incurred for which original bills / receipts / cash memos are enclosed

Total Claim Amount. _____

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.

I ALSO CONSENT AND AUTHORISE THE THIRD PARTY ADMINISTRATOR TO SEEK MEDICAL INFORMATION FROM ANY HOSPITAL / MEDICAL PRACTITIONER WHO HAS ANY TIME ATTENDED ON ME.

Signature of the Claimant …….

Date: ……

Place: …….