# Claim Form

**CLAIM FORM**
(The issue of this Form is not to be taken as an admission of liability)

PART A
TO BE FILLED IN BY THE INSURED (TO BE FILLED IN BLOCK LETTERS)

**Do You Know**

★ Non-submission of original bills and receipts is the main reason for delay in claim settlements. Please provide the originals
★ Provide your bank details for direct/ Electronic Fund Transfer (EFT) for faster claim settlement. Refer Part A - Section G
★ To receive updates on your claim status, please provide your mobile no. & E-mail ID
★ You can check your claim status at: www.maxbupa.com → Claims → Claims status → Login to check status

## SECTIONA - DETAILS OF PRIMARY INSURED

a) Policy No. : b) Sl. No/ Certificate No. :
c) Company/ TPA ID No :
d) Name :
e) Address :
City : State :
Pin Code : Phone No. : Email ID :

## SECTION B - DETAILS OF INSURANCE HISTORY

a) Currently covered by any other mediclaim health insurance Yes ☐ / No ☐
b) Date of commencement of first Insurance for the person (without break) : (DD/MM/YYYY) :
c) If Yes, Company Name :
Policy No. : Sum Insured :
d) Have you been hospitalized in the last four years since inception of the contract? Yes ☐ / No ☐ (DD/MM/YYYY) :
Diagnosis : e) Previously covered by any other Mediclaim/Health insurance Yes ☐ / No ☐
f) If Yes, Company Name :

## SECTION C - DETAILS OF THE INSURED PERSON HOSPITALISED :

a) Name :
b) Relationship : Self ☐ / Spouse ☐ / Child ☐ / Father ☐ / Mother ☐ / Other ☐ (Please Specify) :
c) Date of Birth : d) Age (YY/MM) : e) Gender: Male ☐ / Female ☐
f) Address :
City : State :
Pin Code : Phone No. : Email ID :
g) Occupation : Service ☐ / Self employed ☐ / Homemaker ☐ / Student ☐ / Retired ☐ / Others (Please Specify) :

## SECTION D - DETAILS OF HOSPITALISATION :

a) Name of the Hospital where admitted :
b) Room Category occupied : Day care ☐ / Single occupancy ☐ / Twin sharing ☐ / 3 or more ☐ beds per room
c) Hospitallisation due to Illness ☐/ Injury ☐/ Maternity ☐ : Details :
d) Date of Injury/ Date of disease first detected/ Date of delivery : (DD/MM/YYYY) :
e) Date of admission : (DD/MM/YYYY) : f) Time : (HH/MM) :
g) Date of discharge : (DD/MM/YYYY) : h) Time : (HH/MM) :
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 ☐ iii) MLC Report, & Police FIR attached? Yes ☐ / No ☐
j) System of medicine : Allopathic ☐ / Other systems of medicine ☐

## SECTION E - DETAILS OF CLAIM :

a) Details of the treatment expenses claimed :
i) Pre-hospitalisation Expenses Rs. ii) Hospitalisation Expenses Rs.
iii) Post-hospitalisation Expenses Rs. iv) Health-Check up Cost Rs.



Please dispatch your claim document to: Max Bupa Corporate Office: Bloc B1/I-2, Mohan Cooperative Industrial Estate, Mathura Road, New Delhi -110044.

# Claim Form

v) Ambulance Charges Rs. vi) Others (code) Rs.

Total Rs.

vii) Pre-hospitalisation Period Days viii) Post -hospitalisation Period Days

b) Claim for Domiciliary Hospitalization : Yes ☐ / No ☐ (if yes, please provide details in annexure)

c) Details of Lumpsum / cash benefit claimed :

i) Hospital Daily Cash Rs. ii) Surgical Cash Rs.

iii) Critical Illness Benefit Rs. iv) Convalescence Rs.

v) Pre/Post hospitalisation lumpsum benefit: Rs. vi) Others Rs.

Claim Documents Submitted- CheckList:

- ☐ Duly filled and signed Claim Form
- ☐ Hospital Main Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Pharmacy Bill
- ☐ ECG
- ☐ Investigation Reports ( Including CT, MRI/USG/HPE)
- ☐ Others
- ☐ Copy of intimation letter, if any
- ☐ Hospital Break Up bill
- ☐ Hospital Discharge Summary
- ☐ Operation Threater Notes
- ☐ Doctor's Request for Investigation
- ☐ Doctor's Prescription

## SECTION - F DETAILS OF BILLS ENCLOSED :

| Sl. No. | Bill No. | Date | Issued by | Towards | Amount (Rs.) |
|---|---|---|---|---|---|
| | | D D M M Y Y | | Hospital Main Bill | |
| | | D D M M Y Y | | Pre-hospitalisation Bills:___Nos | |
| | | D D M M Y Y | | Post-hospitalisation Bills:___Nos | |
| | | D D M M Y Y | | Pharmacy Bills | |
| | | D D M M Y Y | | | |
| | | D D M M Y Y | | | |
| | | D D M M Y Y | | | |
| | | D D M M Y Y | | | |
| | | D D M M Y Y | | | |
| | | D D M M Y Y | | | |
| | | D D M M Y Y | | | |

## SECTION - G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT :

a) Account Holder's Name:

b) PAN No : c) Account No :

d) Bank Name : Branch :

e) IFSC Code :

f) Payment option: Cheque ☐ / DD ☐ / NEFT ☐

g) MICR No :

Note: Please submit a cancelled cheque leaf or a copy of latest bank statement or passbook with a/c holder's name, account no. and IFSC code mentioned on it.

## 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 hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalisation claim, if any.

Date : D D M M Y Y Y Y

Place :

Signature of Insured : ☑

# Claim Form

## CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

### In-patient Treatment /Day Care Procedures

- ❑ Duly filled and signed Claim Form.
- ❑ Duly filled and signed Consent Form.
- ❑ Photocopy of ID card / Photocopy of current year policy.
- ❑ Original Detailed Discharge Summary / Day care summary from the hospital.
- ❑ Original consolidated hospital bill with break up of each Item, duly signed by the insured.
- ❑ Original payment Receipt of the hospital bill.
- ❑ First Consultation letter and subsequent Prescriptions.
- ❑ Original bills, original payment receipts and Reports for investigation.
- ❑ Original medicine bills and receipts with corresponding Prescriptions.
- ❑ Original invoice/bills for Implants (viz. Stent /PHS Mesh / IOL etc.) with original 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)

  In Accidental Death cases
- ❑ Copy of Post Mortem Report & Death Certificate

### For Death Cases

In addition to the In-patient Treatment documents:

- ❑ Original Death Summary from the hospital.
- ❑ Copy of the Death certificate from treating doctor or the hospital authority.
- ❑ Copy of the Legal heir certificate, if the claim is for the death of the principle insured.

### Pre and Post-hospitalisation expenses

- ❑ Duly filled and signed Claim Form.
- ❑ Photocopy of ID card / Photocopy of current year policy.
- ❑ Original Medicine bills, original payment receipt with prescriptions.
- ❑ Original Investigations bills, original payment receipt with prescriptions and report.
- ❑ Original Consultation bills, original payment receipt with prescription.
- ❑ Copy of the Discharge Summary of the main claim.

### Outpatient Benefit/Dental

- ❑ Duly filled and signed Claim Form.
- ❑ Photocopy of ID card / Photocopy of current year policy.
- ❑ Original Medicine bills, original payment receipt.
- ❑ Original Investigations bills, original payment receipt with report.
- ❑ Original Consultation bills, original payment receipt with prescription.
- ❑ Details of any Outpatient Procedures, If any
- ❑ Dental X-ray film.

### Daily Cash Benefit

- ❑ Duly filled and signed Claim Form.
- ❑ Photocopy of ID card / Photocopy of current year policy.

### Organ Donation/Transplantation

In addition to the documents of general hospitalisation

- ❑ Organ Function test / blood test proving organ failure.
- ❑ Treatment Certificate issued by the Transplant Surgeon of the hospital concerned.

### Ambulance Benefit

- ❑ Duly filled and signed Claim Form.
- ❑ Photocopy of ID card / Photocopy of current year policy.
- ❑ Original Bill with Original Payment Receipt.
- ❑ Treating Doctor's consultation prescription indicating Emergency Hospitalization.

### Maternity Expenses

In addition to the In-patient Treatment documents:

- ❑ Obstetric history (Gravida, Para, Living children, Abortions) from treating doctor.

### Critical Illness Benefit

- ❑ Duly filled and signed Claim Form.
- ❑ Photocopy of ID card / Photocopy of current year policy.
- ❑ A medical certificate confirming the diagnosis of critical illness from a doctor not less qualified than MD/MS.
- ❑ Investigation reports / other related documents reflecting the critical illness diagnosis.

### Health Check up

- ❑ Duly filled and signed Claim Form.
- ❑ Photocopy of ID card / Photocopy of current year policy.
- ❑ Original Investigation bills, original payment receipts with Reports.
- ❑ Original Consultation bills and original payment receipts with prescription.

### Expenses for spectacles/contact lenses, hearing aids

- ❑ Duly filled and signed Claim Form.
- ❑ Photocopy of ID card / Photocopy of current year policy.
- ❑ Prescription of the Treating Doctor.
- ❑ Original Invoice/bills, original payment receipt of the device, appliances, lens etc.



Please dispatch your claim document to: Max Bupa Corporate Office: Bloc B1/I-2, Mohan Cooperative Industrial Estate, Mathura Road, New Delhi -110044.

**GUIDANCE FOR FILLING CLAIM FORM - PART A :**

| DATA ELEMENT | DESCRIPTION | FORMAT |
|---|---|---|
| SECTION A - DETAILS OF PRIMARY INSURED | | |
| a) Policy No. | Enter the policy number | As allotted by the insurance company |
| b) SI. No/ Certificate No. | Enter the social insurance number or the Certificate number of social health insurance scheme | As allotted by the organization |
| c) Company TPA ID No. | Enter the TPA ID No | License number as allotted by IRDA and printed in TPA documents |
| d) Name | Enter the full name of the policyholder | Surname, First name, Middle name |
| e) Address | Enter the full postal address | Include Street, City and Pin Code |
| SECTION B - DETAILS OF INSURANCE HISTORY | | |
| a) Currently covered by any other Mediclaim / Health Insurance? | Indicate whether currently covered by another Mediclaim / Health Insurance | Tick Yes or No |
| b) Date of Commencement of first Insurance without break | Enter the date of commencement of first insurance | Use dd-mm-yy format |
| c) Company Name | Enter the full name of the insurance company | Name of the organization in full |
| Policy No. | Enter the policy number | As allotted by the insurance company |
| Sum Insured | Enter the total sum insured as per the policy | In rupees |
| d) Have you been Hospitalized in the last 4 years | Indicate whether hospitalized in the last 4 years | Tick Yes or No |
| Date | Enter the date of hospitalisation | Use mm-yy format |
| Diagnosis | Enter the diagnosis details | Open Text |
| e) Previously Covered by any other Mediclaim/ Health Insurance? | Indicate whether previously covered by another Mediclaim / Health Insurance | Tick Yes or No |
| f) Company Name | Enter the full name of the insurance company | Name of the organization in full |
| SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED | | |
| a) Name | Enter the full name of the patient | Surname, First name, Middle name |
| b) Relationship to primary Insured | Indicate relationship of patient with policyholder | Tick the right option. If others, please specify |
| c) Date of Birth | Enter Date of Birth of patient | Use dd-mm-yy format |
| d) Age | Enter age of the patient | Number of years and months |
| e) Address | Enter the full postal address | Include Street, City and Pin Code |
| f) Gender | Indicate Gender of the patient | Tick Male or Female |
| g) Occupation | Indicate occupation of patient | Tick the right option. If others, please specify |
| h) Phone No | Enter the phone number of patient | Include STD code with telephone |
| i) E-mail ID | Enter e-mail address of patient | Complete e-mail address |
| SECTION D - DETAILS OF HOSPITALIZATION | | |
| a) Name of Hospital where admitted | Enter the name of hospital | Name of hospital in full |
| b) Room category occupied | Indicate the room category occupied | Tick the right option |
| c) Hospitalization due to | Indicate reason of hospitalisation | Tick the right option |
| d) Date of Injury/Date Disease first detected/ Date of Delivery | Enter the relevant date | Use dd-mm-yy format |
| e) Date of admission | Enter date of admission | Use dd-mm-yy format |
| f) Time | Enter time of admission | Use hh:mm format |
| g) Date of discharge | Enter date of discharge | Use dd-mm-yy format |
| h) Time | Enter time of discharge | Use hh:mm format |
| i) If Injury give cause | Indicate cause of injury | Tick the right option |
| If Medico legal | Indicate whether injury is medico legal | Tick Yes or No |
| Reported to Police | Indicate whether police report wasfiled | Tick Yes or No |
| MLC Report & Police FIR attached | Indicate whether MLC report and Police FIR attached | Tick Yes or No |
| j) System of Medicine | Enter the system of medicine followed in treating the patient | Open Text |

| SECTION E - DETAILS OF CLAIM | | |
|---|---|---|
| a) Details of Treatment Expenses | Enter the amount claimed as treatment expenses | In rupees (Do not enter paise values) |
| b) Claim for Domiciliary Hospitalization | Indicate whether claim is for domiciliary hospitalisation | Tick Yes or No |
| c) Details of Lump sum/ cash benefit claimed | Enter the amount claimed as lump sum/ cash benefit | In rupees (Do not enter paise values) |
| d) Claim Documents Submitted- Check List | Indicate which supporting documents are submitted | Tick the right option |
| SECTION F - DETAILS OF BILLS ENCLOSED | | |
| Indicate which bills are enclosed with the amounts in rupees | | |
| SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT | | |
| a) Account Holder's Name | Enter the full name | As mentioned in the bank documents |
| b) PAN | Enter the permanent account number | As allotted by the Income Tax |
| c) Account Number | Enter the bank account number | As allotted by the bank |
| d) Bank Name and Branch | Enter the bank name along with the branch | Name of the Bank in full |
| e) IFSC Code | Enter the IFSC code of the bank branch | IFSC code of the bank branch in full |
| f) Cheque/ DD payable details | Enter the name of the beneficiary the cheque/DD should be made out to | Name of the individual/ organization in full |
| SECTION H - DECLARATION BY THE INSURED | | |
| Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. | | |

## PART B

(TO BE FILLED IN BY THE HOSPITAL IN CASE OF CASHLESS CLAIMS)

The issue of this Form is not to be taken as an admission of liability. Please include the original preauthorisation request form in lieu of PART A

### SECTION A - DETAILS OF HOSPITAL

a) Name of the Hospital where treated :

b) Hospital ID :

c) Type of Hospital : Network ☐ / Non-Network ☐

(If non network fill form section E).

d) Name of the treating Doctor : SURNAME FIRST NAME MIDDLE NAME

e) Qualification :

f) Registration No with state code :

g) Phone No :

### SECTION B - DETAILS OF PATIENT ADMITTED

a) Name of the patient : SURNAME FIRST NAME MIDDLE NAME

b) IP Registration Number :

c) Gender: Male ☐ / Female ☐

d) Age (YY/MM) : Y Y M M

Date of Birth (DD/MM/YYYY) : H H M M

e) Date of Admission (DD/MM/YYYY) : D D M M Y Y Y Y

f) Time of Admission (HH/MM) : H H M M

g) Date of Discharge (DD/MM/YYYY) : D D M M Y Y Y Y

h) Time of Discharge (HH/MM) : H H M M

i) Type of Admission : Emergency ☐ / Planned ☐ / Day-care ☐ / Maternity ☐

j) If Maternity

i) Date of delivery (DD/MM/YYYY) : D D M M Y Y Y Y

ii) Gravida Status :

k) Status at time of discharge : Discharged to Home ☐ / Discharged to another Hospital ☐ / Deceased ☐

Total Claimed Amount Rs.

## SECTION C - DETAILS OF AILMENTS DIAGNOSED (PRIMARY)

a) ICD 10 Codes — Description

i) Primary Diagnosis :

ii) Additional Diagnosis :

iii) Co-morbidities :

iv) Co-morbidities :

b) ICD 10 PCS — Description

i) Procedure 1 :

ii) Procedure 2 :

iii) Procedure 3 :

iv) Details of Procedure :

c) Pre-authorization obtained : Yes ☐ / No ☐ d) Pre-authorization No. :

e) If authorization by network hospital not obtained, give reason :

f) Hospitalisation due to Injury ? Yes ☐ / No ☐

i) If Yes, give cause

Self inflicted? Yes ☐ / No ☐ Road Traffic Accident Yes ☐ / No ☐ Substance Abuse /Alcohol Consumption Yes ☐ / No ☐

ii) If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: Yes ☐ / No ☐ (If yes, attach reports)

iii) Medico Legal Yes ☐ / No ☐ iv) Reported to Policy Yes ☐ / No ☐ v) FIR No :

vi) If not reported to Policy give reasons

## SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECKLIST

- ☐ Claim form duly filled and signed
- ☐ Original Pre authorization Request
- ☐ Copy of Pre-authorization approval Letter
- ☐ Copy of photo ID card of patient verified by Hospital
- ☐ Hospital Discharge Summary
- ☐ Operation Theatre Notes
- ☐ Hospital Main Bill
- ☐ Hospital break up Bill
- ☐ Investigation reports
- ☐ CT/MRI/USG/HPE investigation Report
- ☐ Doctor's reference slip for Investigation
- ☐ ECG
- ☐ Pharmacy Bills
- ☐ MLC Report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, Pls specify

## SECTION E - ADITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL

e) Address :

City : State :

Pin Code : Phone No. : Email ID :

c) Registration no with State Code : d) Hospital PAN :

e) No of In-patient Beds : f) Facilities available in Hospital : i) OT : Yes ☐ / No ☐

ii) ICU : Yes ☐ / No ☐ iii) Others :

## SECTION F - DECLARATION BY 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.

Date : D D M M Y Y Y Y Place :

Signature and seal of the Hospital Authority : ☑



Please dispatch your claim document to: Max Bupa Corporate Office: Bloc B1/I-2, Mohan Cooperative Industrial Estate, Mathura Road, New Delhi -110044.

**GUIDANCE FOR FILLING CLAIM FORM - PART B :**

| DATA ELEMENT | DESCRIPTION | FORMAT |
|---|---|---|
| SECTION A - DETAILS OF HOSPITAL | | |
| a) Name of Hospital | Enter the name of hospital | Name of hospital in full |
| b) Hospital ID | Enter ID number of hospital | As allocated by the TPA |
| c) Type of Hospital | Indicate whether In network or non network Hospital | Tick the right option |
| d) Name of treating doctor | Enter the name of the treating doctor | Name of doctor in full |
| e) Qualification | Enter the qualifications of the treating doctor | Abbreviations of educational qualification |
| f) Registration No. with State Code | Enter the registration number of the doctor along with the state code | As allocated by the Medical Council of India |
| g) Phone No. | Enter the phone number of doctor | Include STD code with telephone number |
| SECTION B - DETAILS OF THE PATIENT | | |
| a) Name of Patient | Enter the name of hospital | Name of hospital in full |
| b) IP Registration Number | Enter insurance provider registration number | As allotted by the insurance provider |
| c) Gender | Indicate Gender of the patient | Tick Male or Female |
| d) Age | Enter age of the patient | Number of years and months |
| e) Date of Birth | Enter date of admission | Use dd-mm-yy format |
| f) Date of Admission | Enter date of admission | Use dd-mm-yy format |
| g) Time | Enter time of admission | Use hh:mm format |
| h) Date of Discharge | Enter date of discharge | Use dd-mm-yy format |
| i) Time | Enter time of discharge | Use hh:mm format |
| j) Type of Admission | Indicate type of admission of patient | Tick the right option |
| k) If Maternity | | |
| Date of Delivery | Enter Date of Delivery if maternity | Use dd-mm-yy format |
| Gravida Status | Enter Gravida status if maternity | Use standard format |
| l) Status at time of discharge | Indicate status of patient at time of discharge | Tick the right option |
| m) Total claimed amount | Indicate the total claimed amount | In rupees (Do not enter palse values) |
| SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY) | | |
| a) ICD 10 Code | | |
| Primary Diagnosis | Enter the ICD 10 Code and description of the primary diagnosis | Standard Format and Open text |
| Additional Diagnosis | Enter the ICD 10 Code and description of the additional diagnosis | Standard Format and Open text |
| Co-morbidities | Enter the ICD 10 Code and description of the co-morbidities | Standard Format and Open text |
| b) ICD 10 PCS | | Standard Format and Open text |
| Procedure 1 | Enter the ICD 10 PCS and description of the first procedure | Standard Format and Open text |
| Procedure 2 | Enter the ICD 10 PCS and description of the second procedure | Standard Format and Open text |
| Procedure 3 | Enter the ICD 10 PCS and description of the third procedure | |
| Details of Procedure | Enter the details of the procedure | Open text |
| c) Present Ailment is a Complication of PED | Indicate whether present ailment is a complication of some pre-existing disease | Tick Yes or No |
| d) Pre-authorization obtained | Indicate whether pre-authorization obtained | Tick Yes or No |
| e) Pre-authorization Number | Enter pre-authorization number | As allotted by TPA |
| f) If authorization by network hospital not obtained, give reason | Enter reason for not obtaining pre-authorization number | Open text |

| | | |
|---|---|---|
| g) Hospitalization due to injury | Indicate if hospitalisation is due to injury | Tick Yes or No |
| Cause | Indicate cause of injury | Tick the right option |
| If injury due to substance abuse/ alcohol consumption, test conducted to establish this | Indicate whether test conducted | Tick Yes or No |
| Medico Legal | Indicate whether injury is medico legal | Tick Yes or No |
| Reported To Police | Indicate whether police report was filed | Tick Yes or No |
| FIR No. | Enter first information report number | As issued by police authorities |
| If not reported to police, give reason | Enter reason for not reporting to police | Open Text |
| SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST | | |
| Indicate which supporting documents are submitted | | |
| SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL | | |
| a) Address | Enter the full postal address | Include Street, City and Pin Code |
| b) Phone No. | Enter the phone number of hospital | Include STD code with telephone number |
| c) Registration No. | Enter the registration number of patient | As allocated by the Hospital |
| d) Hospital PAN | Enter the permanent account number | As allotted by the Income Tax department |
| e) Number of Inpatient Beds | Enter the number of inpatient beds | Digits |
| f) Facilities available in the hospital | Indicate facilities available in the hospital | Tick the right option. If others, please |
| SECTION F - DECLARATION BY THE INSURED | | |
| Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. | | |
| SECTION G - DECLARATION BY THE HOSPITAL | | |
| Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp | | |

## CUSTOMER IDENTIFICATION PROCEDURE (AS PER KYC NORMS OF IRDA)

**Please submit clear and legible copy of one document (valid and effective as on date of claim submission) each from Part A and Part B and your recent passport size photograph (not more than 6 months old) incase claim amount exceeds Rs 100,000.**

Photograph

| | |
|---|---|
| **Part A**<br>**Proof of legal name and any other names used** | i. Pan Card<br>ii. If Pan Card is not available please submit any of the documents mentioned below stating reason for not having Pan Card.<br>a) Passport<br>b) Voter's Identity Card<br>c) Driving License<br>d) Personal Identification and Certification of the employees for your identity.<br>e) Letter issued by Unique identification Authority of India containing details of name address and Aadhar Number<br>f) Job Card issued by NREGA duly signed by an officer of the State Government |

| | |
|---|---|
| **Part B**<br>**Proof of Residence** | i. Electricity Bill not older than 6 months from the date of Insurance Contract<br>ii. Telephone Bill pertaining to any kind of telephone connection like mobile, landline, wireless etc. Provided it is not older than 6 months from the date of claim submission<br>iii. Ration Card<br>iv. Valid lease agreement along with rent receipts which is not more than 3 months old as a residence proof<br>v. Saving Bank Passbook with details of permanent/ present residence address ( updated upto 1 month prior to claim submission document)<br>vi. Statement of saving bank account with details of present/ present address ( updated upto 1 month prior to claim submission document) |

I hereby declare that I have submitted above mentioned documents and recent photograph (not more than 6 months old) for the purpose of claim and the said documents are valid and effective.

Date : D D M M Y Y Y Y

Signature of Policyholder : ☑

**(Please attach copy of a cancelled blank cheque of your bank for ensuring accuracy of name of the bank, branch name, Account number and IFSC code. If name of the payee is not printed on the cheque leaf please attach copy of the first page of the bank passbook also )**

To

**Date ___/____/____**

Medical Superintendent

_____

_____

_____

## Consent Letter

I, Mr/Ms _____ age _____resident

of_____ state _____hereby

give my willful consent to Mr/Dr_____ of Max Bupa Health Insurance Company Limited to verify and collect necessary documents/statements including but not limited to certified copies of medical records from your esteemed hospital for the purpose of settlement of my insurance claim.

My other relevant details are provided below;

**Detail of Insured:-**

**DOA:**

**DOD:**

**MRD/Indoor/IP No:**

**Policy No:**

I request you to provide all the information/documents as required by Max Bupa Health Insurance Company Ltd.

**Name:**

**Signature/ Thumb Impression**

**Witness name & Signature**