IndusInd Nippon Life

Reimbursement Claim form

CLAIM FORM PART A

TO BE FILLED BY THE INSURED

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

(To be filled in BLOCK LETTERS)

DETAILS OF THE PRIMARY INSURED

Policy No. Sl No./Certificate No.

Policy Name

Name FIRST MIDDLE LAST

Correspondence Address/ Usual place of residence FLAT NO. BUILDING

ROAD NAME/NO. LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE Pin Code

STD ISD Code LANDLINE MOBILE EMAIL ADDRESS

DETAILS OF INSURANCE HISTORY

Currently covered by any other Mediclaim/Health Insurance Yes No

Date of commencement of first insurance without break (copies of policies to be attached) DD MM YEAR

If Yes, Company name Policy No.

Sum Insured (Rs.) Have you been hospitalized in the last 4 years? Yes No

Date DD MM YEAR Diagnosis

Previously covered by any other Mediclaim/Health Insurance Yes No If Yes, Company name

DETAILS OF THE INSURED PERSON HOSPITALIZED

Name FIRST MIDDLE LAST

Gender Male Female Age Years Months Date of birth DD MM YEAR

Relationship to the Primary Insured Self Spouse Child Father Mother Other (Please Specify)

Occupation Service Self-Employed Homemaker Student Retired Other (Please Specify)

Address (if different from above) FLAT NO. BUILDING

ROAD NAME/NO. LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE Pin Code

STD ISD Code LANDLINE MOBILE EMAIL ADDRESS

DETAILS OF THE INSURED PERSON HOSPITALIZED

Name of the hospital where admitted

Room category occupied Day care Single occupancy Twin sharing 3 or more beds per room

Hospitalization due to Injury Illness Maternity

Date of injury/Date of disease first detected/Date of deliver DD MM YEAR

Date of admission DD MM YEAR Time MM HH

Date of discharge DD MM YEAR Time MM HH

If injury, give cause Self-Inflicted Road traffic accident Substance abuse/Alcohol consumption

If Medico legal Yes No Reported to police Yes No MLC report& police FIR attached Yes No

System of medicine

DETAILS OF THE CLAIM

Details of the treatment expenses claimed

Pre-hospitalization expenses

Post-hospitalization expenses

Ambulance charges

Hospitalization expenses

Health check-up cost

Others (code)

Total

Pre-hospitalization period ____ ____ Days

Post-hospitalization period ____ ____ Days

Claim for domiciliary hospitalization ☐ Yes ☐ No (if yes, provide details in the annexure)

Details of lumpsum/cash benefit claimed

Hospital daily cash

Critical illness benefit

Pre/Post hospitalization

Lumpsum benefit

Surgical cash

Convalescence

others

Total

CLAIM DOCUMENTS SUBMITTED (CHECK LIST)

☐ Claim form duly signed
☐ Copy of the claim intimation
☐ Hospital discharge summary
☐ Doctors request for investigation
☐ Hospital main bill
☐ Hospital break-up bill
☐ Operation theatre notes
☐ Doctors prescription
☐ Hospital bill payment receipt
☐ Pharmacy bill
☐ ECG
☐ Investigation reports (including CT/MRI/USG/HPE)
☐ Others

Details of the Bills Enclosed

SL No.	Bill No.	Date	Issued by	Towards	Amount
1.		D D M M Y E A R		Hospital Main Bill	
2.				Pre-hospitalization Bills Nos	
3.				Post-hospitalization Bills Nos	
4.				Pharmacy Bills	
5.					
6.					
7.					
8.					
9.					
10.					

DETAILS OF THE PRIMARY INSURED PERSON'S BANK ACCOUNT

PAN Card No.

Account No.

Bank name and Branch

B A N K N A M E

B R A N C h N A M E

Cheque /DD Payable details

IFSC Code

Declaration by the Insured

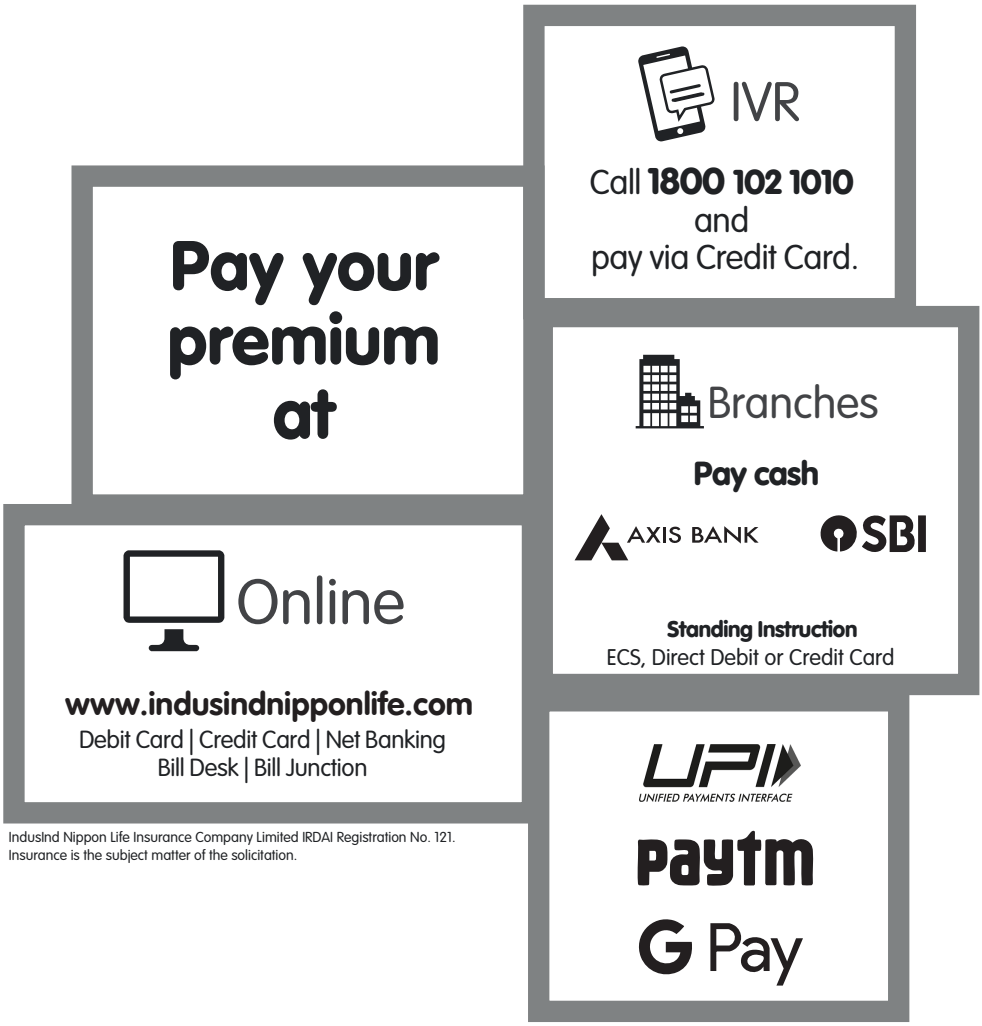
I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA/Insurance 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-hospitalization claim, If any.

Date D D M M Y E A R Place

Signature of the Insured

GUIDANCE FOR FILLING THE CLAIM FORM PART A (To be filled in by the Insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A DETAILS OF THE 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 the 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
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 THE PATIENT ADMITTED		
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 the commencement of the first insurance without break	Enter the date of commencement of the first insurance	Use dd-mm-yy format
c) Company name	Enter full name of the 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 four years	Tick Yes or No
• Date	Enter the date of hospitalization	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 any other 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 THE INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First Name, Middle Name
b) Gender	Indicate gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years & months
d) Date of birth	Enter Date of Birth of the patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with the policyholder	Tick the right option. If others, please specify
f) Occupation	Indicate occupation of the patient	Tick the right option. If others, please specify
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Phone No.	Enter the phone number of the patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of the patient	Complete e-mail address
SECTION D DETAILS OF THE HOSPITALIZATION		
a) Name of the hospital admitted	Enter the name of the hospital	Name of the hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of injury/Date of diseases first detected /Date of delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter the date of admission	Use dd-mm-yy format
f) Time	Enter the time of admission	Use hh-mm format
g) Date of discharge	Enter the date of discharge	Use dd-mm-yy format
h) Time	Enter the time of discharge	Use hh-mm format
i) If injured, give cause	Indicate cause of injury	Tick the right option
• If Medico legal	Indicate whether the injury is Medico legal	Tick Yes or No
• Reported to the police	Indicate whether reported to the police	Tick Yes or No
• MLC Report & police FIR attached	Indicate whether MLC Report & police FIR attached	Tick Yes or No

GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION E DETAILS OF CLAIM		
a) Details of treatment expenses	Enter the amount claim as treatment expenses	In Rupees(Do not enter paise values)
b) Claim for domiciliary hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of lumpsum/cash benefit claimed	Enter the amount claimed as lumpsum/cash benefit	In Rupees(do not enter paise value)
e) Claim documents submitted (check-list)	Indicate which supporting documents are submitted	Tick the right option
SECTION F DETAILS OF THE BILLS ENCLOSED		
Indicate which bills are enclosed with the amount in Rupees		
SECTION G DETAILS OF PRIMARY INSURED BANK ACCOUNT		
a) PAN Card No.	Enter the permanent account number	As allotted by the Income Tax department
b) Account No.	Enter the Bank account number	As allotted by the Bank
c) Bank name & branch	Enter the bank name along with branch	Name of the Bank in full
e) 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
f) IFSC Code	Enter the IFSC code of the Bank branch	IFSC code of the bank branch in full
SECTION H DECLARATION BY THE INSURED		
Read the declaration carefully and mention date (dd/mm/yy format),place (open text)&sign.		



IndusInd Nippon Life Insurance Company Limited IRDAI Registration No. 121.
Insurance is the subject matter of the solicitation.

CIN: U66010MH2001PLC167089

Mktg/BPD/Standard Reimbursement claim Form part A/Ver 1/Nov2025