Health Assurance Claim Form

(For official use only)

Claim No. Date: D D M M Y Y Y Y

Please provide the following information fully to enable us to process your claim appropriately.No.

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 D D M M Y Y Y Y Time of admission

Date of discharge D D M M Y Y Y Y Time of discharge

3. Cover being claimed for:

a). CritiCare

1. Cancer of Specified Severity
2. First Heart Attack of Specified Severity
3. Open Chest CABG
4. Open Heart Replacement or Repair of Heart Valves
5. Coma of Specified Severity
6. Kidney Failure Requiring Regular Dialysis
7. Stroke Resulting in Permanent Symptoms
8. Major Organ/BoneMarrow Transplant
9. Permanent Paralysis of Limbs
10. Motor Neurone Disease with Permanent Symptoms
11. Multiple Sclerosis with Persisting Symptoms
12. Major Burns
13. Fulminant Viral Hepatitis
14. End-stage Lung Disease
15. Aplastic Anemia
16. Loss of Speech
17. Deafness
18. End Stage Liver Disease
19. Muscular Dystrophy
20. Bacterial Meningitis

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 D D M M Y Y Y Y

5. Details of the attending doctor

Name of the doctor

Address of the doctor

City Pin code

Qualification Phone

Registration No.

6. Details of the hospital

Hospital Name

Address of the hospital

City Pin code

State Phone

Registration No.

7. Date of admission D D M M Y Y Y Y

8. Details of claim

	Expense Head	Amount
1.	CritiCare	
2.	HospiCash	
3.	AccidentCare	
	3a. Accident Death	
	3b. Accident Permanent Total Disability	
	3c. Accident Permanent Partial Disability	
	3d. Children's Education Allowance	
	3e. Funeral Expenses	
	3f. Accident Temporary Total Disability	
	3g. Accident Hospitalization	
	Total Claimed Amount (A)	

If you have opted for CritiCare option 2, no seperate 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
c) Copy of First Information Report (FIR)/Panchnama/Inquest report if applicable
d) Copy of Medico Legal Certificate duly attested by the concerned hospital if applicable
e) Final Hospital bill with receipt /copies attested by other insurer if the originals are submitted with them
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

F. CritiCare

a) Duly filled and signed claim form and KYC documents
b) Final 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) Consultation notes and/or investigation reports from outside the hospital prior to hospitalization
e) First consultation note and all medical record since onset of complaint
f) Copy of First Information Report (FIR) (if CritiCare being claimed for is admissible in event of an Accident)
g) Copy of Medico Legal Certificate duly attested by the concerned hospital (if CritiCare being claimed for is admissible in event of an Accident) if applicable

G. HospiCash

a) Duly filled and signed claim form with KYC documents
b) Final 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) ☐ Yes ☐ No

If yes, please give the details as follows:

Name of Insurance Company	Policy No.	Application No.	Insured From (Date)	To (Date)	Sum Insured

12. Is Insured Person at present covered under any Personal Accident cover (Individual or Group) ☐ Yes ☐ No

If yes, please give the details as follows:

Name of Insurance Company	Policy No.	Application No.	Insured From (Date)	To (Date)	Sum Assured

The submission/receipt of this form does not amount to admission of any liability under the claim on the part of the insurers. I here by 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 Bank

Account No. Branch City

IFSC code 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 repect 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 D D M M Y Y Y Y

Name and Signature of Claimant