

**CLAIM FORM**

**Bajaj Allianz ID card no:** \_\_\_\_\_

**Bajaj Allianz Claim No:** \_\_\_\_\_

1.		Name of the Insured/Proposer	:	
2.		Details of the Insured in respect of whom claim is made	:	
	a)	Name	:	
	b)	Present completed Age	:	
	c)	Sex	:	
	d)	Occupation	:	
	e)	Residential Address	:	
	f)	Tel. No.	:	
	g)	Name of the Employee	:	
	h)	Relation with the Employee	:	
3.		Policy No	:	
		Sum Insured	:	
4.		Date that the illness was first detected or bodily injured was sustained	:	
5.		Nature of illness or bodily injured sustained and, in the case of bodily injury, full details of the circumstances giving rise to the bodily injury and the names and contact details of any other person (s) involved	:	
6.		Name and Telephone number of the attending Doctor:	:	
7.		Qualification and registration number of Doctor:	:	
8.		Name,Address & Tel. No of the Hospital / Nursing Home / Clinic where treatment has been obtained	:	
	a)	Registration no.	:	
	b)	No. of Beds in the Hospital	:	
9.		Date of Admission and discharge from the Hospital / Nursing Home / Clinic where treatment has been obtained:	:	
	a)	TOTAL AMOUNT CLAIMED	:	
	b)	Pre-hospitalisation expenses	:	
	c)	Hospitalisation expenses	:	
	d)	Post-hospitalisation expenses	:	

**Document accompanying this claim form (please tick as appropriate)**

- a. Bill, receipt and discharge certificate/ card from the Hospital.
- b. Cash memos from the hospital or chemist supported by proper prescription receipt and Diagnostic Test report from a Diagnostic centre supported by the note from the attending doctor demanding such Diagnostic test.
- c. Surgeon's bill and stamped numbered receipt if surgery is done and surgeon bill is not included in the hospital bill.
- d. Attending doctor's bill and receipt and certificate regarding diagnosis.

**Declaration**

I have incurred on the treatment of the illness or bodily injury referred to above the expenses as per the details given by me in the 'Schedule of the Expenses' overleaf. I hereby warrant the truth of the foregoing particulars in every respect and I further confirm and warrant that there is no other information relevant to my right to claim or the amount of my claim with which would have a bearing upon your consideration of my claim and with which you ought to be acquainted. I confirm that there is no other policy of insurance that might cover me for this claim, and I hereby give my consent and authority for you to seek medical information from any Hospital or Doctor who has at any time attended me whether in relation to the subject matter of this claim or otherwise.

I also hereby confirm that the amount payable to me under the coverage terms and conditions would, when received constitute full and final discharge towards my claim.

**Signature of the claimant**

**Dated :**