Life Insurance

Aditya Birla Sun Life Insurance Company Limited

ADITYA BIRLA CAPITAL

PROTECTING INVESTING FINANCING ADVISING

Request For Cashless Hospitalisation For Medical Insurance Policy

PLEASE FAX / SCAN PAGE 1 ONLY **TO BE FILLED IN BY THE INSURED**

Name of the Hospital:

Hospital Location: Hospital ID:

Hospital Fax No.: Hospital Phone No.:

DETAILS OF THIRD PARTY ADMINISTRATOR

a) Name of TPA / Insurance company:

b) Toll Free Phone Number: c) FAX Number:

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the Patient:

b) Gender: Male ☐ Female ☐ c) Age: Years Months d) Date of birth: D D M M Y Y Y Y

e) Contact number: f) Insured Card ID Number:

g) Policy number / Name of corporate:

h) Employee ID: i) Currently do you have any other Mediclaim / Health Insurance: Yes ☐ No ☐

Company Name:

Give details:

j) Do you have a family physician: Yes ☐ No ☐ k) Name of the family physician:

l) Contact number, if any: (PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)

m) PAN: n) Aadhar No.:

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the treating doctor:

b) Contact Number:

c) Name of ILLNESS / Disease with presenting complaints:

d) Relevant clinical findings:

e) Duration of the present ailment: Days Date of Consultation: D D M M Y Y Y Y

Past history of present ailments if any

f) Provisional diagnosis: i) ICD 10 Code:

g) Proposed line of treatment:

Medical Management ☐ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non- allopathic treatment ☐

h) If investigation & / or Medical Management provide details:

Route of drug administration:

i) If Surgical, name of surgery: i) ICD 10 Code:

j) If other treatments provide details:

k) How did injury occur:

l) In case of accident: i) Is it RTA: Yes ☐ No ☐ ii. Date of Injury: D D M M Y Y Y Y iii. Reported to Police: Yes ☐ No ☐

iv) FIR No.: v) Injury/Disease caused due to substance abuse/alcohol consumption: Yes ☐ No ☐

vi) Test concluded to establish this: Yes ☐ No ☐ (if yes attach reports)

M) In case of Maternity: G ☐ P ☐ L ☐ A ☐ Date of Delivery: D D M M Y Y Y Y

DECLARATION:

I/We hereby

- Declare that the details provided as above are correct andcomplete.
- Authorize ABSLI to process the proceeds under the death claim of the aforesaid policy/s through EFT to the above mentioned account details
- Agree to not hold Aditya Birla Sun Life Insurance Company Limited (ABSLI) or its associate / agent responsible in case of any non credit to my bank account or if the transaction is delayed or not effected at all for reasons of error/ misrepresentation/incomple/tinecorrectinformation furnished by me in this EFT mandate.

PEP - State whether the Policy owner is a Politically Exposed Person Yes ☐ No ☐

PEP. "Individuals who are or have been entrusted with prominent public functions, for example Heads of State or government, senior politicians, senior government, judicial or military officials, Senior executives or state - owned corporation and important political part officials. Business relationship with family members or close associates of PEP's involving reputation risk is similar to those with PEP's themselves".

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in this claim form is true & correct. 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 heareby 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-hospitalizationclaim, if any.

I agree that furnishing of this form, or any forms supplemental thereto, shall not constitute nor be considered an admission by Aditya Birla Sun Life Insurance Co. Ltd. that there was

any assurance in force on the life in question or of its liability there under, nor a waiver of any of its rights or defense. ABSLI reserves the right to call for additional document/requirements.

I hereby provide my consent to receive a call from ABSLI or its authorized Service Providers in connection with any matter related to the above policy.

Date: | D | D | M | M | Y | Y | Y | Y | Place: _____

_____

Signature of the Insured