

Claim form for health insurance policies other than travel and personal accident - PART A

TO BE FILLED IN BY THE INSURED

(TO BE FILLED IN BLOCK LETTERS)

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

DETAILS OF PRIMARY INSURED

a) Policy No: 0 0 3 1 7 1 0 0 2 0 2 1 0 1 b) SI. No/Certificate No: _____

c) Company/TPA ID No: 1 0 9 5 9 4 1 2

d) Name: D A D I G E A M E T I R U M A L E S H A M I D D L E N A M E

e) Address: H N O : 1 - 1 4 0 , V I L L A G E : N O M U L A , M A N D A L : M A N C H A L , D I S T R I C T : R A N G A R E D D Y

City: H Y D E R A B A D State: T E L A N G A N A

Pin Code: 5 0 1 5 0 8 Phone No: 9 9 8 9 1 2 7 8 8 2 Email ID: tirumalesha.dadige@trinamix.com

SECTION A

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: YES NO

b) Date of commencement of first Insurance without break: DD MM YYYY

c) If yes, company name: _____ Policy No: _____

Sum Insured (Rs.) _____

d) Have you been hospitalized in the last four years since inception of the contract? YES NO Date DD MM YYYY

Diagnosis: _____

e) Previously covered by any other Mediclaim / Health insurance : YES NO

f) If yes, Company Name _____

SECTION B

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: B A B Y R O F M E A P A R N A M I D D L E N A M E

b) Gender: Male Female Third Gender c) Age: Years YY Month MM d) Date of Birth: 2 1 0 5 2 1

e) Relationship to Primary insured: Self Spouse Child Father Mother Other

(Please Specify) _____

f) Occupation: Service Self Employed Homemaker Student Retired Other

(Please Specify) N / A

g) Address (if different from above): H N O : 1 - 1 4 0 , V I L L A G E : N O M U L A , M A N D A L : M A N C H A L , D I S T R I C T : R A N G A R E D D Y

City: H Y D E R A B A D State: T E L A N G A N A

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SECTION C

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted: K A M I N E N I H O S P I T A L S L B N A G A R

b) Room Category occupied: Day Care Single occupancy Twin sharing 3 or more beds per room

c) Hospitalization due to: Injury Illness Maternity

d) Date of Injury / Date Disease first detected /Date of Delivery: 2 1 0 5 2 1 e) Date of Admission: 2 1 0 5 2 1

f) Time: 1 2 5 1 g) Date of Discharge: 2 2 0 5 2 1 h) Time: 0 6 0 0 i) If Injury give cause: Self inflicted

Road Traffic Accident Substance Abuse / Alcohol Consumption ii. If Medico legal: YES NO

ii. Reported to police: YES NO iii. MLC Report & Police FIR attached: YES NO j) System of Medicine: _____

SECTION D