

INJURY:Is it arising out of accident: Yes No If yes, please complete the following:Date of accident:

Brief narration of accident _____

Whether FIR filed? Yes No If yes, FIR No. _____
(Attach copy of the same)

Police Station _____

If no, please state reasons for not informing police:
_____Are you currently insured under any other health insurance policies? Yes No
If yes, kindly complete the following table.

Sl. No.	Name & address of Insurance Company	Policy No.	From	To	Sum Insured (Rs.)

Previous claims history

Sl. No.	Name & address of Insurance Company	Nature of illness/disease/injury	Policy No.	Date of Claim	Claim Ref. No.	Sum Insured (Rs.)

Amount of claim (Please mention & include under what head claims are lodged viz. hospitalisation, post-hospitalisation, critical illness etc. & attach separate sheet if the space is insufficient)

Sl. No.	Description	Bill No.	Date	RR	Med.	Dg.	OTC	CF	AF	Nursing	Diet	Others*	Total
	(Hospitalisation/Post-hospitalisation/Critical illness etc.)												
Total													

RR - Room rent, Med. - Medicines, Dg. - Diagnostics, OTC - Operation Theatre Charges, CF - Consultants' Fees, AF - Anaesthetist's Fees, * - Please specify

Please furnish the following list of documents:

- Discharge Summary in full FIR, in injury cases All prescription along with medical reports
 Specialist's certificate confirming the diagnosis with supporting pathological, imaging or any other reports All hospital/drug bills & receipts in original
 Attached physician's statement duly completed by him/her First consultation report
 Surgeon's certificate stating nature of operation performed with detailed operative notes

INSURED'S / PATIENT'S CONSENT FOR ACCESS TO MEDICAL RECORDS & DECLARATION

I/We hereby authorize Bharti AXA General Insurance Co. Ltd. or any other individual/agency engaged by Bharti AXA to obtain all medical records pertaining to the above patient available with any hospital/doctor. The Insurance Company or their representatives or any other authorised agency engaged by them may be allowed access & possession of medical records pertaining to the above patient. The necessary charges will be borne by the Insurance Co. or their authorised agencies.

I/We agree to provide additional information to the Company, if required. I/We the abovenamed, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and if I/We have made, or in any further declaration the Company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, the policy shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited.

Date: _____

Place: _____

Signature of Insured



general insurance

HEALTH INSURANCE CLAIM FORM

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSIBILITY OF LIABILITY.

Please fill this form in **Block Letters** and **Tick the Boxes** where appropriate and do not leave any column unanswered. If any detail or information is not readily available, please do not delay despatch of this report and such particulars may be sent later.

PART - II: ATTENDING PHYSICIAN'S STATEMENT

Name of the Patient: _____

Age Years Gender: Male Female

Address _____

City _____

Pin code _____ State _____

Illness/Disease cases:

Date when patient first reported symptoms of disease/illness :

Diagnosis: _____

Date when patient might have contacted/developed disease/illness in your opinion:

Please provide previous medical history of the patient:

Is the present condition attributable to congenital defect? If yes, please provide details:

Injury cases:

Nature of the accident and details of injuries sustained:

Are the injuries solely due to the accident or traceable to any previous injuries/disease/infirmities?

Nature of treatment/surgery performed for present illness/disease/injury:

Was he under the influence of intoxicants or drugs at the time of accident?
If yes, please provide details of diagnosis done and alcohol content.

Are you his usual medical attendant? Yes No

If yes, please give details of previous treatment for any illness/disease/injury:

Date:

Doctor's Name
(preferably name & address stamp) _____

Registration No. _____

Address _____

Telephone No. _____

Date: _____

Doctor's Signature

Insurance is the subject matter of the solicitation.



general insurance

BHARTI AXA GENERAL INSURANCE COMPANY LIMITED,

First Floor, The Ferns Icon, Survey No. 28, Next to Akme Ballet, Doddanekundi, Off Outer Ring Road, Bangalore- 560037.

Toll Free Helpline: 1800-103-2292 **E-mail:** claims@bharti-axagi.co.in **SMS** <CLAIM> to 5667700

Website: www.bharti-axagi.co.in