Bajaj Allianz General Insurance Company Limited

HOSPITAL CASH DAILY ALLOWANCE POLICY

Claim Form

(PLEASE ANSWER EVERY QUESTION AND FULLY)

The issue or acceptance of this form is not to be construed as admission of liability on the part of the Company

Regional/Branch Office Code

Broker/Agent Name

Code

Insured Details

Name & address of the Insured

Client ID

Details of Insured Person(s) in respect of whom claim is made

1. Name of the Insured Person, Age	
2. Relationship with the Insured	
3. Nature of illness/disease contracted or injury suffered	
4. Date of injury sustained or disease/illness first detected	
5. Name & address of the attending Medical Practitioner	
6. Name & address of the Hospital/Nursing Home where treatment is taken/being taken	
7. (a) Date and time of admission in the Hospital (b) Date and time of discharge from the Hospital Please furnish proof of Hospitalisation like Discharge Summary from the Hospital, Certificate from the attending Medical Practitioner regarding nature illness/disease, injury necessitating hospitalisation.	

8. Do you have any other insurance cover covering Hospital Cash Allowance ? If Yes, give details.	☐ Yes ☐ No

I/We hereby declare that the foregoing statements are true in all respects and that I/We have not attempted to conceal from the company anything with which it ought to be made acquainted and also that if I/We have made or in any further declaration the Company may require shall make any false or fraudulent statement or any suppression, concealment or untrue averment whatever, the Policy shall be void and my/our right to compensation forfeited and am/are willing if required, to make a statutory Declaration before a Justice of the Peace of the truth of the whole of the foregoing statement or any other statement I/We may make in connection with this claim.

Signature of the Insured

Date D D M M Y Y Y Y

Address

Date D D M M Y Y Y Y

(In case of minor children, the Insured may sign)