DOMICILARY CLAIM : CANARA BANK IBA POLICIES

FORM TO BE FILLED BY THE HE INSURED

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

(TO BE FILLED IN BLOCK LETTERS)

A) Details of Primary Insured

i)	Policy No.	
ii)	Employee ID of the Primary Insured	
iii).	MDINDIA Health Card No	MDI5-00
iv)	Name of the Primary Insured	
v)	Address of the Insured	
vi)	Mobile No. (Mandatory)	
vii)	E-mail ID: (Mandatory)	

B) Details of Patient

i)	Name of Patient	
ii)	Gender	
iii).	Age years Months : DOB	
iv)	Relationship to Primary Insured	
v)	Occupation	
vi)	Address (if different from above)	

C) Details of OPD Treatment:

i)	Nature of illness/diagnosis	
ii)	Name of Doctor & Hospital	
iii)	Qualification of Medical Practitioner	
iv)	Address & Registration No of Doctor & Hospital	
v)	Period of Treatment taken.	
vi)	Total amount Claimed	

D) Details of Documents Submitted whichever applicable tick mark√)

i. Original claim form duly singed

ii. *Prescription & certificate of illness – original/ photocopy duly attested (Please tick the relevant field). If photocopy given reasons for the same)*
iii. *Original bills/Paid Receipt of consultation fees.*
iv. *Original pharmacy bills of medicines purchased (Tax invoice with GST No Printed)*
v. *Original bills of Lab test done*
vi. *Reports of the latest pathological investigation confirming diagnosis*
vii. *Self-Declaration form*
viii. *Others.(specify)*

SCHEDULE OF EXPENSES INCURRED AND BEING CLAIMED BY THE CLAIMANT

Ser No	***Bill No***	***Bill Date***	***Nature of Expenditure***	***Amount Claimed (INR)***
	Total			

H) Bank Account Details of Primary Insured (Not required in cases of Serving Employees)

i.	Name of the Account holder :	
ii.	Branch Name :	
iii.	Full Bank Account No.(14 digits)	
iv.	IFSC code (11 Digits)	

I hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. 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 hereby 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-hospitalization claim, if any.

Date

DD / MM/ YYYY **Place:** **Signature of the Primary Insured**