



Bharti AXA Life Insurance Company Limited
 Unit No. 601 & 602, 6th floor, Raheja Titanium, Off Western Express Highway,
 Goregaon (East), Mumbai - 400 063. www.bharti-axalife.com Call Centre: 020 26141350
 Toll Free: 1800-102-4444 (for Airtel subscribers); 1800 425 1350 (for MTNL/BSNL subscribers)

HEALTH CLAIM INTIMATION FORM

(To be completed by the Policyholders)

Please note:

- Only the person entitled to receive the policy monies as stated under the Policy should fill and sign this form.
- Please feel free to insert separate sheet if the space provided is found insufficient.

Issuance of this form does not amount to admission of any claim/liability under the policy on the part of the insurers Please give the following information correctly and completely to enable us process your claim promptly.

1. Documents to be submitted along with this form.

Documents to be submitted	Pleas Tick whichever documents you have submitted
1. Claims Intimation Form duly filled and signed by the Policyholder in original (this format)	
2. Photocopy of Policy Certificate	
3. Treating Doctors Certificate duly filled and signed in original	
4. Attending Physician's Certificate	
5. Attested copy of age proof & address proof	
6. Copies of Medical Records with dates like admission notes, discharge card/summary, procedure/ surgery notes, all medical test reports, prescription notes, previous medical records, Investigation reports, consultation papers & hospital bills etc.	
7. Detailed medical history of the patient, from the treating Doctor (optional)	
8. Any other document as stated in the policy document	

-The Company / Third Party Administrator reserve the right to call for additional documents/ requirements.

2. Policyholder's/ Life Insured details (Patient Details), (Personal Information):

Policy Number	Full Name of Policy Holder	Full Name of Patient	Current Residential Address & Contact No. of Policy Holder

E – Mail ID:Telephone No:

3. Medical history of the Policyholder/ Life Insured (Patient Details): Details of the current illness/ treatment for which claim is logged:

- (a) Nature of Disease/Illness/ Injury sustained:
- (b) Symptoms:
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- (c) Date of onset of symptoms:
- (d) Date of diagnosis:

(e) Date and Time of AdmissionDate and Time of Discharge

(f) When were these Symptoms first evident/ occurred:

4. Details of Attending Medical Practitioner/ Doctor who diagnosed and treated the current illness:

Name and Address of Attending Medical Practitioner	Qualification, Registration No & Contact Details	Date of Admission/ Consultation	Diagnosis

5. Details of Present Hospital

Name and Address of Hospital	Registration No of Hospital & No of Beds in Hospital	Contact Details

6. Name and address of the Policyholder/ Life Insured's (Patient Details) usual Doctor.

Name	Address and contact details

Declaration and Authorization:

I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and I/We agree that if I/We have made, or in any further declaration the Company may require in respect of the said claim, shall make any false or fraudulent statement, or any suppression or concealment the Policy shall be void and all rights to recover there under in respect of past or future claims shall be forfeited.

I HEREBY AUTHORISE on behalf of the patient: (1) Any employer, medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organization, institution or person, that has any records or knowledge of the patient and/or who has attended or may hereafter attend the patient to disclose such information to BHARTI AXA Life Insurance Company; (2) BHARTI AXA Life Insurance Company or any of its appointed medical examiners or laboratories o perform the necessary medical assessment and tests to evaluate the health status of the patient in relation to this claim. This authorization shall bind the patient's successors and remains valid notwithstanding death or incapacity. A photocopy or facsimile copy of this authorization shall be as valid as the original.

**Disclaimer
(To be signed by the Policyholder)**

I hereby declare that the above information is true and correct to the best of my knowledge and belief. If I have made any false, fraud or untrue statement, suppression or concealment, my right to claim for claim amount shall be forfeited.

I hereby declare that I have included all bills/ receipts for the purpose of this claim and I will not be making any supplementary claim in respect thereof.

Signature of the Policyholder
Name of the Policyholder:

Date: _____

Signature of Witness
Name of the Witness:

Date: _____

