MEMORANDUM OF UNDERSTANDING

The Memorandum of understanding executed at Rourkela on this 31st day of July, 2017, between Biju Patnaik University of Technology, Odisha having its headquarters at Rourkela-769015 (hereinafter called 'University') and referred to as the First Party and The New India Assurance Company Ltd. having its Branch Office at Kachery Road, Uditnagar, Rourkela-769012 (hereinafter called 'Company') and referred to as the Second Party.

Whereas :-

(i) By virtue of this MOU, the Company agrees to issue a Students' Package Insurance Policy as per Table-I, in respect of all the students such as

a) Students admitted during 2013-14 to 2017-18 under 5 yr UG Program,
b) Students admitted during 2014-15 to 2017-18 under 4 yr UG Program,
c) Students admitted during 2015-16 to 2017-18 under 3 yr UG(LE) Program and
d) Students admitted during 2015-16 to 2017-18 under 3 yr PG Program

e) Students admitted during 2016-17 to 2017-18 under 2 yr PG Program,

And continuing studies in different colleges/ institutions affiliated to Biju Patnaik University of technology, Odisha, Rourkela.

Period of Insurance: The Students' Package Insurance Policy as per Table-I is valid for a period of twelve months from the commencement of the policy i.e. from 01.08.2017.
Premium: Premium (including service tax) has been received from the University vide Cheque No.312341 dated 31.07.2017 drawn on State Bank of India, Udinagar Branch, Rourkela for Rs.71,00,000/- (Rupees seventy one lakhs only) by the Company. It is understood that the insurance cover shall attach only in respect of those students for whom premium has been paid in advance and also to the subsequent inclusion of students for whom the premium will be paid by the University accordingly. The balance amount, if any, after final calculation, will be returned to the University.

Details of Insured Persons: The University shall provide the details of the students to be covered under the policy. The personal details to be provided would include name, address & registration number along with the names of earning parent/guardian of each student. The admitting college/institution will be the nominee. The disbursement of the settled claim amount will be paid through the college to the students/students’ parents/guardians as the case may be. The discharge of the payment given by the admitting college/institution will be final.

The coverage of the scheme and sum insured is as per Table - I mentioned as below:

<table>
<thead>
<tr>
<th>Sl</th>
<th>Type of Insurance Cover</th>
<th>Sum insured per Student</th>
<th>Beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Death of the student continuing in BPUT due to accident</td>
<td>Rs. 2,00,000/-</td>
<td>Parent of the student concerned</td>
</tr>
<tr>
<td>B</td>
<td>If the accident results in irrecoverable loss of sight of one eye or loss of use of one limb of the student insured</td>
<td>Rs. 1,00,000/-</td>
<td>Student himself (through college)</td>
</tr>
<tr>
<td>C</td>
<td>If the accident results in grievous injury to any limbs of the student insured</td>
<td>Rs. 1,00,000/-</td>
<td>Student himself (through college)</td>
</tr>
<tr>
<td>D</td>
<td>Accident results in total irrecoverable loss of sight of both eyes or loss of use of two limbs or loss of sight of one eye and loss of use of one limb of the student insured</td>
<td>Rs. 2,00,000/-</td>
<td>Student himself (through college)</td>
</tr>
<tr>
<td>E</td>
<td>Death of earning parents / guardian (as per University records) resulting from injury caused by an accident</td>
<td>Rs. 2,00,000/-</td>
<td>Student himself (through college)</td>
</tr>
<tr>
<td>F</td>
<td>The student or earning parent / guardian (as per University record) becoming permanent total disabled because of an accident</td>
<td>Rs. 2,00,000/-</td>
<td>Student himself (through college)</td>
</tr>
<tr>
<td>G</td>
<td>Reimbursement of the cost of hospitalization to the student as an inpatient due to illness/disease/injury. Such cost will include the cost of room rent/boarding expenses provided by hospital/nursing home expenses, fees of surgeon, Doctor and specialist fee. It will also include OT charges, cost of blood, anesthesia,</td>
<td>Upto Rs. 50,000/-</td>
<td>Student himself (through college)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>H</strong></td>
<td><strong>I</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Buffer sum insured to be kept as reserve for the students to meet the expenses arising out of extreme Medical cases only as per decision of the competent authority of BPUT</td>
<td>Theft of laptop/ study materials of the student insured</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rs. 10,00,000/-(Overall cap for all the insured student)</td>
<td>Upto Rs. 30,000/-</td>
<td>Student himself (through college)</td>
<td></td>
</tr>
<tr>
<td>Student himself (through college)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(ii) This MOU also covers mid-term inclusion of students in the Students' Package Insurance Policy as per Table-I. The university shall pay the premium as per pro-rata rate for the period i.e. from the date of inclusion of the student till the expiry of the policy.

**Insurance Cover: Comprehensive Student Insurance Scheme 2017-18**

**Personal Accident Insurance – Students**

It is agreed that the Company shall pay to the Insured Person or the nominee if any of the Insured Person sustains any bodily resulting solely and directly from accident caused by external, violent and visible means, the sum hereinafter set forth in respect of any of the insured persons:-

1. If such injury shall, within twelve calendar months of its occurrence be the sole and direct cause of the death or permanent disablement of the insured student, the capital sum insured of Rs.2,00,000/- (two lakhs only).

2. If the accident results in irrecoverable loss of sight of one eye or loss of use of one limb of the student, the capital sum insured of Rs.1,00,000/- (one lakh only).

3. If the accident results in grievous injury to any limbs of the student insured, the capital sum insured of Rs.1,00,000/- (one lakh only).

4. If the accident resulting in injury shall within twelve calendar months of its occurrence be the sole and direct cause of loss of sight of both eyes or loss of use of two limbs or loss of sight of one eye and loss of use of one limb of the student, then a sum of Rs.2,00,000 (two lakhs only).

**Personal Accident Insurance – Parents**

It is agreed that the Company shall pay a sum of Rs.2,00,000/- (two lakhs only) to the insured student, if the named earning Parent/Guardian of the insured student (as per University records) shall sustain any bodily injury resulting solely and directly from an accident caused by...
external, violent and visible means, and if such injury shall be the sole and direct cause of the death or permanent disablement of the named earning parent/guardian.

It is understood that the exception, i.e. the situations/contingencies under which the Company shall not be liable under the policy, are as per the Student's Package Insurance Policy.

**Hospitalization Benefits—Students**

The Policy covers reimbursement of Hospitalization expenses incurred by the student as an inpatient due to disease/illness/injury sustained by him/her. This being tailor made policy, exclusion clause 4.1, 4.2 & 4.3 of standard GMC stands deleted. In the event of any claim becoming admissible under this policy, the Company will pay to the insured student through the college/institution the amount of such expenses as would fall under different heads mentioned below, and as are reasonably and necessarily incurred thereof by or on behalf of such insured students, but not exceeding the sum insured of Rs.50,000/- (fifty thousand) during the policy period.

1. Room, Boarding and Nursing Expenses as provided by the Hospital/Nursing home.
2. I.C. Unit expenses.
4. Anesthesia, Blood, Oxygen, Operation Theater charges, Surgical Appliances, Medicines and Drugs, Diagnostic Materials, and X-ray, Dialysis, Chemotherapy, Cost of Pacemaker, Artificial limbs and Cost of Organs and similar expenses.
5. Ambulance expenses.

Company’s Liability in respect of all claims admitted during the period of insurance shall not exceed Rs.50,000/- per student.

It is understood that, the terms conditions definitions exclusions etc. of the Students' Package Insurance Policy shall apply in the settlement of the claims.

**Buffer Sum Insured**

It is agreed that, in case of an admissible claim if the medical expenses of the insured student exceeds the covered amount of Rs.50,000/- as per Section-G of Table-I then the excess amount is to be paid by the Company to the student out of the Buffer Sum Insured of Rs.10,00,000/- as per the decision of the competent authority of BPUT on case to case basis.

**Insurance Cover for Laptops/Study Materials**

It is agreed that the company shall pay to the insured student a maximum up to Rs.30,000/- in case of loss of Laptop/Study materials due to theft.

It is understood that, the terms conditions definitions exclusions etc. of the Student’s Package Insurance Policy shall apply in the settlement of the claims.

**Claim Procedure:** Upon the happening of any event which may give rise to claim under the policy, written claim intimation with full particulars to be given to the Company immediately by either the insured student or by the college. All supporting claim documents (as detailed below) will be submitted to the company within 60 days of discharge from the hospital/nursing
home, in case of hospitalization claims. As regards to personal accident claims, the supporting claim documents must be submitted to the company at the earliest. The Company shall not be liable to make any payment in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent statement or device for intimation and submission of the claim documents, the contact Authority of the Company and his/her address is as under:-

<table>
<thead>
<tr>
<th>Authority</th>
<th>Postaladdress</th>
<th>Telephone (Office)</th>
<th>E-mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sr. Branch Manager</td>
<td>City Branch, Kachery Road, Rourkela-769012</td>
<td>Tel: 0661-2500693 Fax:</td>
<td><a href="mailto:sakti.maiti@newindia.co.in">sakti.maiti@newindia.co.in</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><a href="mailto:nia.550501@newindia.co.in">nia.550501@newindia.co.in</a></td>
</tr>
</tbody>
</table>

**Students’ Package Insurance Policy**

The following documents would be submitted to the company in support of the claim (as per Table –I).

1. **(Sl. A to F as per Table I)**
   - **Death claims:**
     1. Claim form duly completed
     2. Death certificate from the competent authority.
     3. Police Report wherever applicable
     4. Post-mortem Report and Viscera Report wherever applicable
     5. Statement of the official of the College.
     7. Copy of College/Institution ID Card

   - **Injury Claims:**
     1. Claim form duly completed
     2. Police reports wherever applicable
     4. Investigation Report like laboratory tests, X-ray and reports essential for confirmation of the injury.
     5. Copy of BPUT Regn. Card
     6. Copy of College/Institution ID Card.
     7. Statement of the officials of the college.
     8. Voter ID Card or any other Identification of earning parent (incase of accidental death of parent)

2. **(Section G as per Table-I)**
   1. Claim form duly completed.
   2. Doctor’s advice for hospitalization.
   3. Bills, from chemist(s) supported by proper prescription.
   4. Bills, receipts and discharge certificate from the hospital.
   5. Receipts and Pathological test reports from Pathologists
   6. Nature of operation performed and surgeon’s bill and receipt
   7. Copy of BPUT Regn. Card
   8. Copy of College/Institution ID Card.

3. **(Section I as per Table I)**

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Registrar

Biju Patnaik University of Technology, Odisha
Rourkela – 15
1. Claim form duly completed
2. Proof of purchase/purchase bill
3. Police reports
4. Letter of subrogation & undertaking
5. Copy of BPUT Regn. Card
6. Copy of College/Institution ID Card.

**Time Limit for Settlement of Claims:**

The disposal of the claims will be done within 15 working days from the **date of receipt of the Relevant documents as stated above.** In cases where a claim would require an investigation, the same will be done with promptitude, and in any case their disposal will not be delayed beyond 15 working days from the receipt of **Investigation report.** Only in extreme cases where the genuineness (or otherwise) of a claim cannot be established within the aforesaid time frame for reasons beyond the control of the Company, the matter shall be brought to the notice of the University/College, and further action as deemed fit would be taken after mutual consent and to be disposed off within 15 days.

It is also agreed that the company shall communicate the status of claims reported, processed, and settled to the University on every quarterly basis during the period of insurance.

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**FOR AND ON BEHALF OF**
**THE NEW INDIA ASSURANCE CO.LTD**

[Signature]
Sr. Branch Manager
Rourkela Branch

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**FOR AND ON BEHALF OF**
**BIJU PATNAIK UNIVERSITY OF TECHNOLOGY, ODISHA, ROURKELA**

[Signature]
Registrar, B.P.U.T. Odisha
Rourkela

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Biju Patnaik University of Technology, Odisha
Rourkela - 15
CLAIM FORM FOR HEALTH INSURANCE POLICIES FOR INJURY/ILLNESS- (PART-A)
TO BE FILLED IN BY THE INSURED: STUDENT SAFETY ILLNESS & EMPLOYEE MEDICLAIM POLICY

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

**DETAILS OF PRIMARY INSURED** (To be filled in block letters) (STRIKE OUT WHICH EVER IS NOT APPLICABLE)

<table>
<thead>
<tr>
<th>a) Policy No:</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) Company/TPAID No:</td>
</tr>
<tr>
<td>c) Sl. No/ Certificate No:</td>
</tr>
<tr>
<td>d) Name:</td>
</tr>
<tr>
<td>e) Address:</td>
</tr>
<tr>
<td>State:</td>
</tr>
<tr>
<td>Email ID:</td>
</tr>
</tbody>
</table>

**DETAILS OF INSURANCE HISTORY:**

| a) Currently covered by any other Mediclaim / Health Insurance: Yes /No |
| b) Date of commencement of first Insurance: D D M M Y Y |
| c) If yes, company name: |
| Policy No: |
| Sum Insured: Rs. Rs. Rs. Rs. Rs. Rs. Rs. |
| d) Have you been hospitalized in the last four years since inception of the contract? Yes /No |
| Diagnosis: |
| e) Previously covered by any other Mediclaim / Health insurance: Yes /No |
| c) If yes, company name: |

**DETAILS OF INSURED PERSON HOSPITALIZED:**

| a) Name: | S U R N A M E |_ F I R S T N A M E |_ M I D D L E N A M E |
| b) Gender: Male | Female |
| c) Age: years | months |
| b) Date of Birth: D D M M Y Y |
| e) Relationship to Primary insured: (Please Specify) Self | Spouse | Child | Father | Mother | Other |
| f) Occupation: Service | Self Employed | Homemaker | Student | Retired | Other |
| (Please Specify) |
| g) Address (if different from above): City: |
| State: | Phone No: |
| Email ID: |
| Pin Code: |

**DETAILS OF HOSPITALIZATION:**

| a) Name of Hospital where Admitted: |
| 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: D D M M Y Y |
| e) Date of Admission: D D M M Y Y |
| f) Time: H H : M M |
| g) Date of Discharge: D D M M Y Y |
| h) Time: H H : M M |
h) If Injury give cause & Details:

DETAILS OF CLAIM:
a) Details of the treatment expenses claimed:
   i) Pre-hospitalization Expenses:
   ii) Hospitalization Expenses:
   iii) Post-hospitalization Expenses:
   iv) Health-Check up Cost:
   v) Ambulance Charges:
   vi) Others (code):

Total

vii) Pre-hospitalization period: Days
viii) Post-hospitalization period:

b) Claim for Domiciliary Hospitalization:

c) Details of Lump sum / cash benefit claimed:
   i) Hospital Daily Cash:
   ii) Surgical Cash:
   iii) Critical Illness Benefit:
   iv) Convalescence:
   v) Pre/Post hospitalization Lump sum benefit:
   vi) Others:

Total

Yes /No (If yes, provide details in annexure)

☐ Claim Form Duly signed
☐ Copy of the claim intimation, if any
☐ Hospital Main Bill
☐ Hospital Break-up Bill
☐ Hospital Bill Payment Receipt
☐ Hospital Discharge Summary
☐ Pharmacy Bill
☐ Operation Theatre Notes
☐ ECG
☐ Doctor's request for investigation
☐ Investigation Reports (Including CT/ MRI / USG / HPE)
☐ Doctor's Prescriptions
☐ Others

/
## DETAILS OF BILLS ENCLOSED:

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Bill No</th>
<th>Date</th>
<th>Issued by</th>
<th>Towards</th>
<th>Amount (Rs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>D D M M Y Y</td>
<td>Hospital Main Bill</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>D D M M Y Y</td>
<td>Pre-hospitalization Bills: Nos</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>D D M M Y Y</td>
<td>Post-hospitalization Bills: Nos</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>D D M M Y Y</td>
<td>Pharmacy Bills</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## DETAILS OF PRIMARY INSURED’S BANK ACCOUNT:

- a) Pan No.: 
- b) Account No.: 
- c) Bank Name and Branch: 
- d) Cheque/ DD Payable details: 
- e) IFSC Code: 

## DECLARATION BY THE INSURED:

I hereby declare that the information furnished in this 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: Place: Signature of the Insured:

## GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)

<table>
<thead>
<tr>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>FORMAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Policy No.</td>
<td>Enter the policy number</td>
<td>As allotted by the insurance company</td>
</tr>
<tr>
<td>b) SI. No/ Certificate No.</td>
<td>Enter the social insurance number or the certificate number of social health insurance scheme</td>
<td>As allotted by the organization</td>
</tr>
<tr>
<td>c) Company TPAID No.</td>
<td>Enter the TPAID No</td>
<td>License number as allotted by IRDA and printed in TPA documents</td>
</tr>
<tr>
<td>d) Name</td>
<td>Enter the full name of the policyholder</td>
<td>Surname, First name, Middle name</td>
</tr>
<tr>
<td>e) Address</td>
<td>Enter the full postal address</td>
<td>Include Street, City and Pin Code</td>
</tr>
</tbody>
</table>

## SECTION B - DETAILS OF INSURANCE HISTORY

<table>
<thead>
<tr>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>FORMAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Currently covered by any other Mediclaim / Health Insurance?</td>
<td>Indicate whether currently covered by another Mediclaim / Health Insurance</td>
<td>Tick Yes or No</td>
</tr>
<tr>
<td>b) Date of Commencement of first Insurance without break</td>
<td>Enter the date of commencement of first insurance</td>
<td>Use dd-mm-yy format</td>
</tr>
<tr>
<td>c) Company Name</td>
<td>Enter the full name of the insurance company</td>
<td>Name of the organization in full</td>
</tr>
<tr>
<td>Policy No.</td>
<td>Enter the policy number</td>
<td>As allotted by the insurance company</td>
</tr>
<tr>
<td>Sum Insured</td>
<td>Enter the total sum insured as per the policy</td>
<td>In rupees</td>
</tr>
<tr>
<td>Question</td>
<td>Instructions</td>
<td>Type</td>
</tr>
<tr>
<td>----------</td>
<td>--------------</td>
<td>------</td>
</tr>
<tr>
<td>d) Have you been Hospitalized in the last four years since inception of the contract?</td>
<td>Indicate whether hospitalized in the last four years</td>
<td>Tick Yes or No</td>
</tr>
<tr>
<td>Date</td>
<td>Enter the date of hospitalization</td>
<td>Use mm-yyyy format</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Enter the diagnosis details</td>
<td>OpenText</td>
</tr>
<tr>
<td>e) Previously Covered by any other Mediclaim/Health Insurance?</td>
<td>Indicate whether previously covered by another Mediclaim/Health Insurance</td>
<td>Tick Yes or No</td>
</tr>
<tr>
<td>f) Company Name</td>
<td>Enter the full name of the insurance company</td>
<td>Name of the organization in full</td>
</tr>
</tbody>
</table>

**SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED**

<table>
<thead>
<tr>
<th>Field</th>
<th>Instructions</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Name</td>
<td>Enter the full name of the patient</td>
<td>Surname, First name, Middle name</td>
</tr>
<tr>
<td>b) Gender</td>
<td>Indicate Gender of the patient</td>
<td>Tick Male or Female</td>
</tr>
<tr>
<td>c) Age</td>
<td>Enter age of the patient</td>
<td>Number of years and months</td>
</tr>
<tr>
<td>d) Date of Birth</td>
<td>Enter Date of Birth of patient</td>
<td>Use dd-mm-yyyy format</td>
</tr>
<tr>
<td>e) Relationship to primary Insured</td>
<td>Indicate relationship of patient with policyholder</td>
<td>Tick the right option. If others, please specify.</td>
</tr>
<tr>
<td>f) Occupation</td>
<td>Indicate occupation of patient</td>
<td>Tick the right option. If others, please specify.</td>
</tr>
<tr>
<td>g) Address</td>
<td>Enter the full postal address</td>
<td>Include Street, City and Pin Code</td>
</tr>
<tr>
<td>h) Phone No.</td>
<td>Enter the phone number of patient</td>
<td>Include STD code with telephone number</td>
</tr>
<tr>
<td>i) E-mail ID</td>
<td>Enter e-mail address of patient</td>
<td>Complete e-mail address</td>
</tr>
</tbody>
</table>

**SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED**

<table>
<thead>
<tr>
<th>Field</th>
<th>Instructions</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Name of Hospital where admitted</td>
<td>Enter the name of hospital</td>
<td>Name of hospital in full</td>
</tr>
<tr>
<td>b) Room category occupied</td>
<td>Indicate the room category occupied</td>
<td>Tick the right option</td>
</tr>
<tr>
<td>c) Hospitalization due to</td>
<td>Indicate reason of hospitalization</td>
<td>Tick the right option</td>
</tr>
<tr>
<td>d) Date of Injury/Date Disease first detected/Date of Delivery</td>
<td>Enter the relevant date</td>
<td>Use dd-mm-yyyy format</td>
</tr>
<tr>
<td>e) Date of admission</td>
<td>Enter date of admission</td>
<td>Use dd-mm-yyyy format</td>
</tr>
<tr>
<td>f) Time</td>
<td>Enter time of admission</td>
<td>Use hh:mm format</td>
</tr>
<tr>
<td>Section</td>
<td>Details</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td><strong>SECTION E - DETAILS OF CLAIM</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Details of Treatment Expenses</td>
<td>Enter the amount claimed as treatment expenses In rupees (Do not enter paise values)</td>
<td></td>
</tr>
<tr>
<td>b) Claim for Domiciliary Hospitalization</td>
<td>Indicate whether claim is for domiciliary hospitalization Tick Yes or No</td>
<td></td>
</tr>
<tr>
<td>c) Details of Lump sum/ cash benefit claimed</td>
<td>Enter the amount claimed as lump sum/ cash benefit In rupees (Do not enter paise values)</td>
<td></td>
</tr>
<tr>
<td>d) Claim Documents Submitted-Check List</td>
<td>Indicate which supporting documents are submitted Tick the right option</td>
<td></td>
</tr>
<tr>
<td><strong>SECTION F - DETAILS OF BILLS ENCLOSED</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicate which bills are enclosed with the amounts in rupees</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SECTION G - DETAILS OF PRIMARY INSURED'S BANKACCOUNT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) PAN</td>
<td>Enter the permanent account number As allotted by the Income Tax department</td>
<td></td>
</tr>
<tr>
<td>b) Account Number</td>
<td>Enter the bank account number As allotted by the bank</td>
<td></td>
</tr>
<tr>
<td>c) Bank Name and Branch</td>
<td>Enter the bank name along with the branch Name of the Bank in full</td>
<td></td>
</tr>
<tr>
<td>d) Cheque/ DD payable details</td>
<td>Enter the name of the beneficiary the cheque/ DD should be made out to Name of the individual/ organization in full</td>
<td></td>
</tr>
<tr>
<td>e) IFSC Code</td>
<td>Enter the IFSC code of the bank branch IFSC code of the bank branch in full</td>
<td></td>
</tr>
<tr>
<td><strong>Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CLAIM FORM - PART B</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TO BE FILLED IN BY THE HOSPITAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The issue of this Form is not to be taken as an admission of liability Please include the original preauthorization request from in lieu of PART A</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DETAILS OF HOSPITAL (To be filled in block letters)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Name of the hospital:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Hospital ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Type of hospital: Network: Non Network: (if non network fill section E)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Name of the treating doctor:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Qualification:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Registration No. with State Code:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Phone No.:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DETAILS OF THE PATIENT ADMITTED</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Name of the Patient:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) IP Registration Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Gender Male Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Age: years months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Date of Birth: D D M M Y Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Date of Admission: D D M M Y Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Time: H H : M M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) Date of Discharge: D D M M Y Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Time: H H : M M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j) Type of Admission: Emergency: Planned: Day Care : Maternity:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k) If Maternity:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Date of Delivery: D D M M Y Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii) Gravida Status:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>l) Status at time of discharge: Discharge to home:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge to another hospital:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deceased:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>m) Total claimed amount:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### DETAILS OFAILMENT DIAGNOSED (PRIMARY)

<table>
<thead>
<tr>
<th>a)</th>
<th>ICD 10 Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Primary Diagnosis:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii) Additional Diagnosis:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii) Co-morbidities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iv) Co-morbidities:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b)</th>
<th>ICD 10 PCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Procedure 1:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii) Procedure 2:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii) Procedure 3:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iv) Details of Procedure:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>c) Pre-authorization obtained:</th>
<th>Yes</th>
<th>No</th>
<th>d) Pre-authorization Number:</th>
</tr>
</thead>
</table>

| e) If authorization by network hospital not obtained, give reason: | | |

<table>
<thead>
<tr>
<th>f) Hospitalization due to injury:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>i)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii) If Yes, give cause:</td>
<td>Self-inflicted</td>
<td>Road Traffic Accident</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance abuse / alcohol consumption</th>
</tr>
</thead>
<tbody>
<tr>
<td>iii) If injury due to substance abuse / alcohol consumption, Test conducted to establish this:</td>
</tr>
<tr>
<td>iv) If Medico legal:</td>
</tr>
<tr>
<td>iv) Reported to Police:</td>
</tr>
<tr>
<td>v) FIR No.:</td>
</tr>
</tbody>
</table>

| vi) If not reported to police give reason: | | |

### CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- Claim Form duly signed
- Original Pre-authorization request
- Copy of the Pre-authorization approval letter
- Copy of Photo ID Card of patient Verified by hospital
- Hospital Discharge summary
- OperationTheatre Notes
- Hospital main bill
- Hospital break-up bill

- Investigation reports CT/MR/USG/HPE
- Investigation reports
- Doctor's reference slip for investigation
- ECG
- Pharmacy bills
- MLC reports & Police FIR
- Original death summary from hospital where applicable
- Any other, please specify
DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

- a) Address: [ ]
  - City: [ ]
  - State: [ ]
  - Pin Code: [ ]

- b) Phone No: [ ]

- c) Registration No. with State Code: [ ]

- d) Hospital PAN: [ ]

- e) Number of inpatient beds: [ ]

- f) Facilities available in the hospital: [ ]
  - i) OT: [ ] Yes [ ] No
  - ii) ICU: [ ] Yes [ ] No
  - iii) Others: [ ]

DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: [ ]

Place: [ ]

Signature and Seal of the Hospital Authority: [ ]

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)

<table>
<thead>
<tr>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>FORMAT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SECTION A - DETAILS OF HOSPITAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Name of the hospital</td>
<td>Enter the name of hospital</td>
<td>Name of the hospital in full</td>
</tr>
<tr>
<td>b) Hospital ID</td>
<td>Enter ID number of hospital</td>
<td>As allocated by the TPA</td>
</tr>
<tr>
<td>c) Type of Hospital</td>
<td>Indicate whether in network or non network hospital</td>
<td>Tick the right option</td>
</tr>
<tr>
<td>d) Name of treating doctor</td>
<td>Enter the name of the treating doctor</td>
<td>Name of doctor in full</td>
</tr>
<tr>
<td>e) Qualification</td>
<td>Enter the qualification of the treating doctor</td>
<td>Abbreviations of educational qualifications</td>
</tr>
<tr>
<td>f) Registration No. with State Code</td>
<td>Enter the registration number of the doctor along with the state code</td>
<td>As allocated by the Medical Council of India</td>
</tr>
<tr>
<td>g) Phone No.</td>
<td>Enter the phone number of doctor</td>
<td>Include STD code with telephone number</td>
</tr>
<tr>
<td><strong>SECTION B - DETAILS OF THE PATIENT ADMITTED</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Name of Patient</td>
<td>Enter the name of patient</td>
<td>Name of patient in full</td>
</tr>
<tr>
<td>b) IP Registration Number</td>
<td>Enter insurance provider registration number</td>
<td>As allotted by the insurance provider</td>
</tr>
<tr>
<td>c) Gender</td>
<td>Indicate Gender of the patient</td>
<td>Tick Male or Female</td>
</tr>
<tr>
<td>d) Age</td>
<td>Enter age of the patient</td>
<td>Number of years and months</td>
</tr>
<tr>
<td>e) Date of Birth</td>
<td>Enter date of birth</td>
<td>Use dd-mm-yy format</td>
</tr>
<tr>
<td>f) Date of Admission</td>
<td>Enter date of admission</td>
<td>Use dd-mm-yy format</td>
</tr>
<tr>
<td>g) Time</td>
<td>Enter Time of admission</td>
<td>Use hh:mm format</td>
</tr>
<tr>
<td>h) Date of Discharge</td>
<td>Enter date of Discharge</td>
<td>Use dd-mm-yy format</td>
</tr>
<tr>
<td>i) Time</td>
<td>Enter time of Discharge</td>
<td>Use hh:mm format</td>
</tr>
<tr>
<td>j) Type of Admission</td>
<td>Indicate type of admission of patient</td>
<td>Tick the right option</td>
</tr>
<tr>
<td>k) If Maternity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Date of Delivery</td>
<td>Enter Date of Delivery if maternity</td>
<td>Use dd-mm-yy format</td>
</tr>
<tr>
<td>ii) Gravida Status</td>
<td>Enter Gravida status if maternity</td>
<td>Use standard format</td>
</tr>
<tr>
<td>l) Status at time of discharge</td>
<td>Indicate status of patient at time of discharge</td>
<td>Tick the right option</td>
</tr>
<tr>
<td>m) Total claimed amount</td>
<td>Indicate the total claimed amount</td>
<td>In rupees (Do not enter paise values)</td>
</tr>
<tr>
<td>DATA ELEMENT</td>
<td>DESCRIPTION</td>
<td>FORMAT</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
<td>--------</td>
</tr>
<tr>
<td><strong>SECTION C - DETAILS OF ILLNESS DIAGNOSED (PRIMARY)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) ICD 10 Code</td>
<td>Enter the ICD 10 Code and description of the primary diagnosis</td>
<td>Standard Format and Open text</td>
</tr>
<tr>
<td>Primary Diagnosis</td>
<td>Enter the ICD 10 Code and description of the primary diagnosis</td>
<td>Standard Format and Open text</td>
</tr>
<tr>
<td>Additional Diagnosis</td>
<td>Enter the ICD 10 Code and description of the additional diagnosis</td>
<td>Standard Format and Open text</td>
</tr>
<tr>
<td>Co-morbidities</td>
<td>Enter the ICD 10 Code and description of the Co-morbidities</td>
<td>Standard Format and Open text</td>
</tr>
<tr>
<td>b) ICD 10 PCS</td>
<td>Enter the ICD 10 Code and description of the first procedure</td>
<td>Standard Format and Open text</td>
</tr>
<tr>
<td>Procedure 1</td>
<td>Enter the ICD 10 Code and description of the second procedure</td>
<td>Standard Format and Open text</td>
</tr>
<tr>
<td>Procedure 2</td>
<td>Enter the ICD 10 Code and description of the third procedure</td>
<td>Standard Format and Open text</td>
</tr>
<tr>
<td>Procedure 3</td>
<td>Enter the details of the procedure</td>
<td>Open text</td>
</tr>
<tr>
<td>Details of Procedure</td>
<td>Enter the details of the procedure</td>
<td>Open text</td>
</tr>
<tr>
<td>c) Pre-authorization obtained</td>
<td>Indicate whether pre-authorization obtained</td>
<td>Tick Yes or No</td>
</tr>
<tr>
<td>d) Pre-authorization Number</td>
<td>Enter pre-authorization number</td>
<td>As allotted by TPA</td>
</tr>
<tr>
<td>e) If authorization by network hospital not obtained, give reason</td>
<td>Enter reason for not obtaining pre-authorization number</td>
<td>Open text</td>
</tr>
<tr>
<td>f) Hospitalization due to injury</td>
<td>Indicate if hospitalization is due to injury</td>
<td>Tick Yes or No</td>
</tr>
<tr>
<td>Cause</td>
<td>Indicate cause of injury</td>
<td>Tick the right option</td>
</tr>
<tr>
<td>If injury due to substance abuse/alcohol consumption test conducted to establish this</td>
<td>Indicate whether test conducted</td>
<td>Tick Yes or No</td>
</tr>
<tr>
<td>Medico Legal</td>
<td>Indicate whether injury is medico legal</td>
<td>Tick Yes or No</td>
</tr>
<tr>
<td>Reported to Police</td>
<td>Indicate whether police report was filed</td>
<td>Tick Yes or No</td>
</tr>
<tr>
<td>FIR No.</td>
<td>Enter first information report number</td>
<td>As issued by police authorities</td>
</tr>
<tr>
<td>If not reported to police, give reason</td>
<td>Enter reason for not reporting to police</td>
<td>Open text</td>
</tr>
<tr>
<td><strong>SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicate which supporting documents are submitted</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL</strong></td>
<td>Include Street, City and Pin Code</td>
<td></td>
</tr>
<tr>
<td>a) Address</td>
<td>Enter the full postal address</td>
<td>Include STD code with telephone number</td>
</tr>
<tr>
<td>b) Phone No.</td>
<td>Enter the phone number of hospital</td>
<td></td>
</tr>
<tr>
<td>c) Registration No. with State Code</td>
<td>Enter the registration number of the Hospital obtained from local body like City Corporation / Municipality</td>
<td>As allocated by the City Corporation / Municipality</td>
</tr>
<tr>
<td>d) Hospital PAN</td>
<td>Enter the permanent account number</td>
<td>As allocated by the Income Tax Department</td>
</tr>
<tr>
<td>e) Number of Inpatient beds</td>
<td>Enter the number of inpatient beds</td>
<td>Digits</td>
</tr>
<tr>
<td>f) Facilities available in the hospital</td>
<td>Indicate facilities available in the hospital</td>
<td>Tick the right option. If others, please specify</td>
</tr>
<tr>
<td><strong>SECTION F - DECLARATION BY THE HOSPITAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. and stamp</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>