

## Claim form major surgical benefit (To be filled in block letters by the Claimant/Principal Insured)

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S. No.	POLICY No.	
1.	Name of the Policy holder	
(a)	Date of commencement of base plan	
(b)	Date of commencement of major surgical rider	
2.	Details of the insured person: (in respect of whom claim is made)	
(a)	Relationship with the insured	
(b)	Present completed age	
(c)	Gender	
(d)	Occupation	
3.	Sum Assured	
4.	Date of Injury sustained or Disease/Illness First detected	
5.	Nature of Disease/illness contracted or injury suffered	
6.	Name of the surgical procedure performed	
7.	Name of the attending Medical Practitioner	
(a)	Address of the attending Medical Practitioner	
(b)	Telephone No.	
(c)	Qualification	
(d)	Registration No.	
8.	Name & Address of the hospital/nursing home/clinic	
(a)	Registration Number	
(b)	No. of beds in the Hospital	
(c)	Date of Admission	
(d)	Date of Discharge	
(e)	Date of Surgery	
9.	Have you lodged any claim under this policy or any other health insurance policy including Mediclaim, critical illness etc? If yes, please provide the following details.	
(a)	Name of the company	
(b)	Diagnosis	
(c)	Whether settled/repudiated	
(d)	Amount	
10.	Was any benefit paid under this policy for this rider earlier?	Yes No If Yes, please mention
(a)	Date of Payment	
(b)	Sum Assured Paid	

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Claimant Contact No.							
Name of the Branch CCE							
SAP Code of the CCE							
Contact No. of the CCE							
Email ID of the CCE							
Date of receiving the Claim Form at the branch							

Signature of Declarant

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Signature of the CCE