सिंडिकेटबैंक
SyndicateBank

मानव संसाधन विभाग / HUMAN RESOURCES DEPARTMENT
कर्मचारी कल्याण प्रभाग / STAFF WELFARE DIVISION
प्रधान कार्यालय : मणिपाल / HEAD OFFICE: MANIPAL

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संदर्भ सं./Ref.No. 791-2017-NT-HRD-SWD दिनांक/Date: 21.11.2017

NOTIFICATION

SUB: IBA GROUP HEALTH INSURANCE POLICY FOR RETIREES 2017-18

We have been Informed by United India Insurance Co.Ltd the Lead Insurer that as per the premium remitted by the Bank the Group Health Insurance Policies for the Retirees of our Bank is renewed for the year 2017-18. The details are given here under:-

1) **Policy No: 5001002817P111696409 (Without Domiciliary Cover)**

2) **Policy No: 5001002817P111698565 (With Domiciliary Cover)**

Period of Coverage: From 01/11/2017 to 31/10/2018

All the Retirees/Staff-Family Pensioners are requested to invariably quote the above policy number in all the claim forms (both hospitalisation and domiciliary treatment) / correspondence with the TPA and the Insurer. Domiciliary treatment claim format for the year 2017-18 wherein the policy number is mentioned is attached as Annexure.

महा प्रबंधक (मा.सं.)
GENERAL MANAGER (HR)

DOMICILIARY CLAIM FORM

TO BE FILLED BY THE 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 THE PRIMARY INSURED:

i)	Policy No.	**5001002817P111698565**
ii)	SL No./Certificate No.	**(N A)**
III)	EMP NO	
iv).	TPA Card No.	
v)	Name of Insured	
vI)	Address of the Insured	
vii)	Phone No. (Mandatory)	
viii)	E-mail ID: (Mandatory)	

B) DETAILS OF CLAIMANT

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

C) Details of OP Treatment:

i)	Nature of illness	
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	
vii)	OP Treatment	

D) Details OF INSURANCE HISTORY: *(NOT APPLICABLE)*

i) Currently covered by any other Medi claim / Health Insurance :	
ii) Date of Commencement of first Insurance without Break :	
ii) IF yes, Company name :	
iv) Policy No.:	
v) Sum Insured (Rs :)	
vi) Have you been hospitalized in the last four years since inception of the contract?	→ NA ←
vi) IF yes Date & Diagnosis	
vii) Previously covered by any other Mediclaim /Health insurance	
viii) If yes, company name :	

E) DETAILS OF HOSPITALIZATION : *(NOT APPLICABLE)* :

I) Name of Hospital Where Admitted :	
ii) Room Category occupied :	
iii) Hospitalization due to : Injury/Illness/Maternity	→ NA ←
iv) Date of Injury/ Date Disease first detected /Date of Delivery :	
v) Date of Admission :	

vi) Time of Admission :	
viii) Date of Discharge:	
viiii) Time of Discharge :	
ix) If injury give cause :	
x) Substance abuse /Alcohol Consumption :	N A
xi)If medico legal :	
xii) Reported to Police :	
xiii) MLC Report	
xiiii) System of Medicine :	

F) DETAILS OF OP TREATMENT : (*Not applicable*)

I) Pre- hospitalization expenses ii)Hospitalization expenses
iii) Post hospitalization expenses iv) Health- Check up cost iv)Ambulance

G) **DETAILS OF DOCUMETS SUBMITTED (whichever applicable tick mark √)**

i) **Hospital Main Bill (NOT APPLICABLE)**
ii) **Hospital Break –up bill (NOT APPLICABLE)**
iii) **Hospital Bill payment Receipt (NOT APPLICABLE)**
iv) **Hospital Discharge Summary (NOT APPLICABLE)**
iv) Original claim form duly singed
v) Pharmacy Bill
vi) Prescription & certificate of illness – **original / photocopy duly attested**
(Please tick the releyant field). If photocopy given reasons for the same.
vii) Original bills of consultation fees.
viii) Original bills of medicines purchased
ix) Original bills of Lab test done
x) Reports of the Lab test.
xi) Others.

SCHEDULE OF EXPENSES INCURRED AND BEING CLAIMED BY THE CLAIMANT

SL. No.	Receipt No.	Receipt Date	Nature of Expenditure	Amt. claimed(₹)	Amt. payable(₹)

H) DETAILS OF PRIMARY INSURED'S BANK ACCOUNT DETAILS:

I)	Name of the Account holder :	
ii)	PAN NO :	
iii)	Branch Name :	
iv)	Full Bank Account no.(14 digits)	
v)	IFSC code (11 Digits)	
vi)	Cheque / DD No.	

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 Insured**