

documents submitted is found to be tampered with or is not genuine, then, subject to any other remedy AEGON Religare Life Insurance Company (ARLIC) may have in respect of this claim, the claim made by me herein is liable to be repudiated by ARLIC solely on that ground and if any of the documents submitted by me are found to be tampered with or are not genuine, ARLIC may also, in its sole discretion, declare the policy null and void. I hereby authorise the representative of TPA, M/s Paramount Health Services (TPA) Pvt. Ltd. ("TPA") and AEGON Religare Life Insurance Company (ARLIC) and its authorised representative free and unlimited access to seek medical information (Indoor case papers, reports, documents, including photocopies thereof/pertaining to the insured's admission/treatment etc.,) from any hospital/medical practitioner from which the Insured member has at any time sought or availed of medical attention concerning any disease/sickness, ailment or injury, which affects or may affect the physical or mental health of the insured.

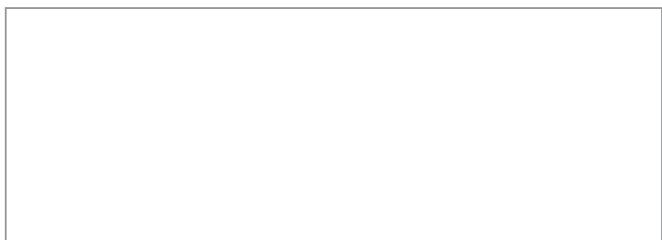
I also hereby authorise the hospital/attending doctor/medical practitioner from whom the Insured member has sought or availed of any medical attention/medical treatment concerning any disease/sickness, ailment or injury which has affected the Insured member's physical/mental health, to share the above information and make available the records relating to such medical attention /medical treatment to the TPA/ARLIC or their authorised representative/s treating them as the "authorised attendant" under regulation 1.3.2 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002. I/my successors/assigns shall not raise any dispute or litigation on passing of such information to the TPA or ARLIC or its authorised representatives.

Name of the Policyholder: _____

Signature of the Policyholder: _____

Date:

Place: _____



(Insured's Photo ID – With Hospital Attestation)

DECLARATION BY THE HOSPITAL

We hereby declare & confirm that the information furnished in Section II of this claim form is true & correct.

Name & Seal of the Hospital: _____

Authorised Signatory of the Hospital: _____

Date:

Place: _____

NOTE: Please submit this "Claim Form" with all the enclosures to your TPA. The claim form along with the "Claim Discharge Form" should be submitted collectively to enable claim processing.

Claim Documents Checklist (Please tick) whichever is appropriate/applicable to the claim being made):

- | | | |
|--|------------------------------|-----------------------------|
| a) Duly filled & signed Claim Form | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) Attested true copies of Indoor Case Papers of the Hospital | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) Discharge Summary of Present & Past (if applicable) Hospitalisation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) Summary of procedure in case of Daycare treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e) Hospital Main Bill*/Hospital Break-up Bills* | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f) Cash memos from Doctor, Chemist, Diagnostic Centres/Hospitals | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g) Investigation Reports/Reports Name | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h) First consultation papers, OPD papers, medicine details | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i) Implant Name, sticker /invoice (if any) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j) Police FIR/MLC copy (In case of Injury or accident ,if applicable) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k) Death Certificate (if applicable) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| l) Others (if any) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| m) Total No. of pages enclosed | <input type="text"/> | <input type="text"/> |

