



**CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIMS UNDER INDIVIDUAL POLICY**

[Please tick (P) the appropriate box]

Name of the Claimant: \_\_\_\_\_

UHID Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ No. of Enclosures: \_\_\_\_\_

Duly filled in Claim Form  
 Photocopy of ID card

**General:**

Original copy of consolidated bill on pre-printed stationery with serial number and IP number of hospital, with breakup

Original copy of the receipt of payment  
 All original prescriptions for the bills attached

All the Original Investigation Reports

Original Discharge summary in pre-printed stationery of hospital, duly signed by the treating doctor, with hospital seal and registration number

Original invoice for Implants (viz. Stent / PHS mesh / IOL etc.)

First consultation letter for the presenting complaints

Original copies of doctor's consultation prescription / notes  
 Treating Doctor's certificate regarding presenting complaints its etiology, past history of presenting complaints along with duration

Cancelled cheque along with IFSC details (or) copy of the Bank pass book.

Submission of Photo Id & address proof is mandatory.

Pre-hospitalization prescriptions  
 Original prescription / doctor notes of previous treatment for the presenting complaint

Date of previous operation (if any) along with copy of discharge summary

**For Death Cases:**

Attested copy of death summary in pre-printed stationery of hospital signed by the treating doctor with hospital seal and registration number

Attested copy of death certificate from competent authority

Legal heir certificate / Letter from the underwriting office directing FHPL to settle the claim in the name of the nominee / dependent(s)

**For Maternity Cases:**

Original copy of treating doctor certificate regarding obstetric history (Gravida, Para, Living children, Abortions, Death)

**For RTA:**

Attested copy of MLC report

Attested copy of FIR

Original copy of treating doctor's certificate with circumstances and injuries sustained due to RTA

Original copy of treating doctor's certificate for any evidence of influence of alcohol / other narcotics substance during the accident

Do you have any other Health Insurance Policy? Yes / No  
 Sum Insured: \_\_\_\_\_

If yes, please specify policy number: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_

**Undertaking:**  
 I / we hereby confirm that the above -mentioned documents in support of the **claimed amount** have been submitted in full and final. No other documents would be submitted on a later date, that will alter / enhance the claimed value.

Date: \_\_\_\_\_  
 Place: \_\_\_\_\_ Signature \_\_\_\_\_  
 Full Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 City: \_\_\_\_\_ Pin: \_\_\_\_\_  
 Contact Number: (Res) \_\_\_\_\_  
 (Mobile) \_\_\_\_\_  
 Email: \_\_\_\_\_

**Disclaimer:**  
 We acknowledge receipt of your claim and confirm that it has been registered with us on the basis of the above - mentioned documents. However, the above acknowledgement does not guarantee settlement / payment of the claimed amount. This claim will be subjected to pass through medical and commercial scrutiny, which may call for additional documents that needs to be submitted within the stipulated time frame on intimation.

Date: \_\_\_\_\_ Signature \_\_\_\_\_ Signature \_\_\_\_\_  
 Place: \_\_\_\_\_ Claimant \_\_\_\_\_ For FHPL \_\_\_\_\_