के.के. वाघ शिक्षण संस्था, नाशिक

मध्यवर्ती कार्यालय, हिराबाई हरिदास विद्यानगरी,
अमृतधाम, पंचवटी, नाशिक-४२२ ००३.

जा. क्र. : के.के. वाघ एज्यु. सो./७६३७/२०१६ दिनांक 4 OCT 2016

ऑफिस नोट

संस्थेने विद्यार्थ्यांसाठी समुह वैद्यकीय विमा योजना सुरू केलेली आहे. सदर योजनेत सहभागी झालेल्या विद्यार्थ्यांचे आजारपण/दुर्घटना प्रसंगी विमा Claim करण्यासाठी खालील प्रमाणे सूचना देण्यात येत आहे.

अ) आजारपण व दुर्घटना प्रसंगी विद्यार्थ्यांच्या पालकांनी कागदपत्रे पुर्ततेसाठी खालील व्यक्तींशी फोन द्वारे संपर्क करावयाचा आहे.

१. श्री.राजेश - ७०३०९१७००३
२. श्री.वैभव - ७०३०९१७००२
३. श्री.सुबोध - ७०३०९२१४५१
४. डॉ.एस.एम.निकम - ७०३०९२१४५५

Health India TPA Services, Suyojit Sankul,
Basement Shop No.11, Tilakwadi Corner,
Near Rajiv Gandhi Bhavan, Nashik-422002.
swapnil.nikam@healthindiatpa.com

५. श्री.आर.बी.तिवारी - ९४२३१७९९२८ - rbtiwari@kkwagh.edu.in
६. कु.एन.आर.कोहकडे - ९१७५६६५२९४ - nrkohakade@kkwagh.edu.in

ब) आजारपण/अपघात याची माहिती त्वरीत वरील १ ते ६ पैकी कोणत्याही व्यक्तीशी संपर्क साधुन फोन व ई-मेल आयडीवर द्यावयाची आहे.

क) विमा Claim साठी खालील प्रमाणे कागदपत्राची आवश्यकता असते.

१. हॉस्पीटल रजिस्ट्रेशन मुळ झेरॉक्स
२. हॉस्पीटल C Form व IPD कागदपत्रे
३. रक्त तपासणी अहवाल व बील/पावती
४. औषधाचे बील व डॉक्टरांचे औषध योजना (Prescription)
५. हॉस्पीटलचे मुळ बीले/ पावती
६. X-ray USG अहवाल व बील/पावती
७. हॉस्पीटलचा मुक्ती दाखला (Discharge Card)
८. विद्यार्थ्यांचे ओळखपत्र
९. पालकाचे बँक खात्याचा रद्द (Cancel) केलेला चेक

सोबत Claim Form व इतर आवश्यक कागदपत्रे यांची यादी जोडत आहोत.

तसेच या व्यतिरिक्त विमा कंपनीचे मागणी नुसार लागणारी कागदपत्रे द्यावयाची आहेत. वरील सर्व कागदपत्रे महाविद्यालयात किंवा वर दिलेल्या Health India TPA Services Pvt.Ltd. या कंपनीच्या पत्त्यावर जमा करावीत व काही शंका असल्यास श्री.आर.बी तिवारी यांच्याशी संपर्क करावा. सदर कागदपत्रांच्या मुळ प्रती विमा कंपनीत दाखल करण्यासाठी द्यावयाच्या असुन झेरॉक्स प्रत पालकांनी त्यांच्या माहितीसाठी ठेवावयाची आहे.

सर्व विभागप्रमुखांना कळविणेत येते की, सदरची ऑफीस नोट सर्व विद्यार्थ्यांच्या निदर्शनास आणुन द्यावी.
KN 4/10

Mrs. Maniyar to put on website
KNadf 4/10

वित्त व्यवस्थापक
के.के.वाघ शिक्षण संस्था, नाशिक

सोबत- वरीलप्रमाणे

प्रत:
१. मा.सचिव सो, के.के.वाघ शिक्षण संस्था, नाशिक
२. प्रा.पी.टी. कडवे, समन्वयक-तीनही तंत्रनिकेतन
३. डॉ. व्ही.एम. सेवलीकर, समन्वयक- सरस्वतीनगर कॅम्पस
४. डॉ. बी.व्ही. कर्डिले, समन्वयक- महाविद्यालय व शाळा
५. श्री. मुरारी आर.वाय., ऑफिसर इनचार्ज, मध्यवर्ती कार्यालय
६. श्री. आर.बी. तिवारी, कुलसचिव- कु. नुतन कोहकडे यांना कळवावे.

प्रत: सर्व संलग्न संस्था व हॉस्टेल (अनुदानित शाळा वगळून)

K.K.Wagh Institute of Engineering Education & Research Nashik-422 003
- 4 OCT 2016
Inward No. 1548
File No.
Initial

The New India Assurance Company Limited

Registered & Head Office: New India Assurance Building, 87, M.G. Road, Fort, Mumbai - 400 001.

MEDICLAIM POLICY (2007)

CLAIM FORM

Claim Number

Issuance of this form does not amount to admission of any liability of under the policy on the part of the Insurers
Please give the following information correctly and completely to enable us process your claim promptly.

All dates to be entered as Date / Month / Year

1. Name of the Insured: ________________ SURNAME ______ INITIALS
(in whose name policy is issued)

2. Details of the Insured person : ____________
(in respect of whom claim is made) :
   - (a) Name & Relationship with the Insured : ____________
   - (b) Present Completed Age : ____________
   - (c) Occupation : ____________
   - (d) Residential Address : ____________
   ____
   - (e) Bank Details
     - (i) Account No ____________
     - (ii) Name of the Bank - ____________
     - (iii) Branch : ____________

3. Policy Number (In Full) : ☐☐ ☐☐☐☐ ☐☐☐☐

4. Nature of Disease contracted/Ailment suffered or injury sustained ____________

5. Date on which injury was sustained/Disease Or ailment first detected : ____________

6. (a) Name and Address of the attending Medical Practitioner : ____________
   : ____________
   Pin Code ____________
   State/ U. Territory ____________
   - (b) Qualification & Telephone No. : ____________
   - (c) Registration No. : ____________

(d) Name & Address of the Hospital/Nursing Home / Clinic : _____

_____

_____

Pin Code _____

State / U. Territory _____

PAN of Hospital _____

Registration No. _____

(e) Date of Admission : _____

(f) Date of Discharge : _____

6. Are you at present covered under any other similar type of scheme like Personal Accident, Cancer Insurance, Mediclaim (Individual or Group), Health Insurance and the like. If Yes. Please give particulars of each

Sr. No.	Content	Details
	Name of Insurer	
	Insurance Scheme	
	Policy No.	
	Period of cover	
	Claim Amt. Recd./receivable	

(a) Is this the first year of coverage under Mediclaim Policy? Yes / No.

If no, since when have you been continuously insured under Mediclaim Policy. Give details

Year Policy No.	Insurer	Policy No.

(b) (i) Is this the first claim under this policy ? **Yes/No**

(ii) If no, please quote Previous claim details

Year	Policy No.	Insurer	Disease/Ailment/Injury details	Amount claimed and receivable or received

In support of the above claim, I enclose the following original documents (Please indicate by √)

1. Bill, Receipt and Discharge certificate / card from the Hospital.
2. Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.
3. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests /pathological
4. Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.
5. Attending Doctor's/ Consultant's/ Specialist's / Anaesthetist's bill and receipt, and certificate regarding diagnosis.
6. Certificate from attending Medical Practitioner / Surgeon that the patient is fully cured.

Summary of expenses incurred for which original bills / receipts / cash memos are enclosed.

Total of Hospital Bill	Rs. _____
Consultant's /Surgeon's /Anesthetist's Fees	Rs. _____
Diagnostics Tests	Rs. _____
Medicines purchased from chemists	Rs. _____
Other expenses not included above (specify)	Rs. _____
Grand Total	Rs. _____

DECLARATION

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment of any fact, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are availed or claimed under any other Medical Scheme or Insurance.

I ALSO CONSENT AND AUTHORISE THE NEW INDIA ASSURANCE COMPANY LIMITED & THIRD PARTY ADMINISTRATOR TO SEEK MEDICAL INFORMATION FROM ANY HOSPITAL / MEDICAL PRACTITIONER WHO HAS AT ANY TIME ATTENDED ON ME.

I authorize TPA to make payment of the claim admissible as per terms, conditions and limitations of the policy to the **Hospital** on my behalf for full and final settlement of hospital bills.

I also authorize TPA to receive payment from the insurance company as reimbursement of hospital bills incurred on my / the insured person's treatment.

Dated at...(place)..... this..... day of...(month).....200

Signature of the Claimant

ELECTRONIC CLEARANCE SYSTEM FORM

Name of Account Holder	
Name of Bank	
Branch Name	
Branch Address	
Type of Account:	
Account Number	
IFSC	

Important information to the Policy holder / claimants opting for NEFT:

1. All the information mentioned above mandate form should be filled correctly.
2. The policy holder / claimant should also submit either the Photocopy of cheque leaf or the Photocopy of the page of the passbook / cheque book where details of the Account Holder Name, IFSC, Account Number are mentioned.
3. The account of the policy holder / annuitant should be operational at the time of receipt of policy payment.
4. Before submitting the mandate form, the policyholder/ claimant should confirm from his bank that it is NEFT enabled.
5. Policy holder's/ claimants' name under the policy should match with that of Bank A/c, else it is likely to be rejected.

Declaration

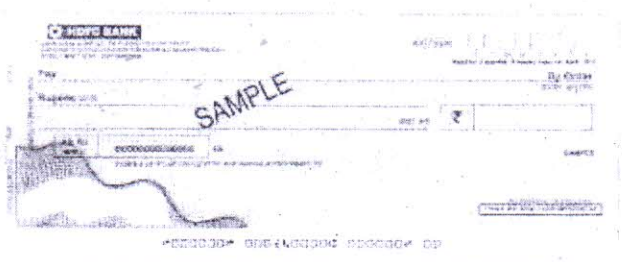
1. I hereby declare that the information furnished in this ECS Form is true & correct to the best of my knowledge & belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to claim reimbursement shall be forfeited.
2. I agree that I shall not hold TPA/Insurance Company responsible for delay or non-receipt of the payment for any reason whatsoever after issue of the instructions for payment by Insurer/TPA based on the above.
3. As per the revised RBI guidelines, Canceled cheque should have pre-printed name of account holder.

Date:
Place:

Signature of the Policy Holder

----------**SAMPLE CHEQUE FORMAT** ----------

Note: Claims Number / Policy number / MDID number to be mentioned on cancel cheque and Please enclose the cancelled cheque of your bank account for our record; your banker should be a participant of NEFT/RTGS Facility.



Health-India TPA Services Pvt. Ltd.

1	Maternity	Discharge summary/card/report	
		Latest USG report (Ultra Sonography Report) / Birth Certificate	
		Obstretic History in GPLA Format on Hospital Letter Head	
		Hospital bill with detail break up	
		Paid money receipt signed & revinew stamp (Only for the amount above Rs.5000/-)	
		Doctor prescription note for Medical test adviced	
		All Medical test report	
		Doctor to certify gravida, Para & no of living issues on the hospital letter head.	
		Doctor precption on L.M.P & E.D.D	
		Doctor prescription/advice for the medicines	
		No pre-post hospitalisation is payable in Maternity's case.	
		Xerox of Indoor Case Papers duly stamp and sign	
		Xerox Copy of Hospital Registration Certificate / Form C	
2	Accident	Discharge summary/card/report	
		Hospital bill with detail break up	
		Paid money receipt signed by revinew stamp (Only for the amount above Rs.5000/-)	
		Doctor prescription note for Medical test adviced	
		All Medical test report like X-Ray etc.	
		Doctor prescription/advice for the medicines	
		All relevant bills for medicine prescribe.	
		X-Ray/MRI/CT Scan plate	
		Doctor advice for X-Ray/MRI/CT Scan test	
		Self declaration from patient as to how, when & where accident happen	
		MLC / FIR from Hospital or Policy Chowky	
		Xerox of Indoor Case Papers duly stamp and sign	
		Xerox Copy of Hospital Registration Certificate / Form C	
3	General	Discharge summary/card/report	
		Hospital bill with detail break up	
		Paid money receipt signed by revinew stamp (Only for the amount above Rs.5000/-)	
		Doctor prescription note for Medical test adviced	
		All Medical test report	
		Doctor prescription/advice for the medicines & Investigations Done	
		All relevant bills for medicine prescribe & Investigations Done	
		Xerox of Indoor Case Papers duly stamp and sign	
		Xerox Copy of Hospital Registration Certificate / Form C	
4	Pre-Post Hospitalization	Xerox copy of the Discharge summary/card/report	
		Xerox copy of the Hospital bill with detail break up	
		Doctor prescription/advice for the medicines	
		All relevant bills for medicine prescribe.	
		Doctor prescription/advice for the all medical tests done	
		All Medical test report required	
5	NOTE 1	***Bank details and cancel cheque is required for payment through RTGS/NEFT no cheque will be issued under any circumstance***	
	2	***Claim intimation is mandetory within 24hr to TPA/IC/HR***	
	3	***If claim is submitted after 15 days from the date of discharged ;mandetory to submit clarification for the same***	
	4	***30 days for Pre-Hospitalization & 60 days for Post-Hospitalization***	
	5	**Xerox Copy of Hospital Registration Certificate / Form C**	

Name and sign Submitted by

Received by Sign and stamp