# Status At The Time Of Investigation

| Claim Number             | - | 20130000943                                      | Claim Amount -     | 22000        |
|--------------------------|---|--------------------------------------------------|--------------------|--------------|
| Claim Status             | - | Open                                             | Claim Sub Status - | Finalization |
| Current Status From GIST |   |                                                  |                    |              |
| Claim Status             | - | Open                                             | Claim Sub Status - | Finalization |
| Claim Date               | - |                                                  | Settled Amount -   |              |
| Policy Details           |   |                                                  |                    |              |
| Product Name             | - | Kotak Group Health Care Non<br>Employer Employee | Policy Number -    | 1045355500   |
| IMD NAME                 | - | BANC ASSURANCE A GST                             | IMD Code -         | 1171360000   |
| IMD Flag                 | - | Red                                              | Policy Type -      | Floater      |

Policy Start Date-01-01-1900Policy End Date-01-01-1900

Policy Category

-

Policy Sub Type -

Policy Holder - PRABHA NIVAS,MANAMBOOR, THOTTAKKADU PO,OPP RAMESHWARAM TEMPLE Address THIRUVANANTHAPURAM KERALA

# Member Details

| Member Name -                 |                    | Member ID                  | - | 1001333121            |
|-------------------------------|--------------------|----------------------------|---|-----------------------|
| Certificate Number -          | 1045355500-KGI-GHI | Relation                   | - | Son                   |
| Sum Insured -                 | 0                  | Addition Effective<br>Date | - | 06/12/2021            |
| First Policy Incept -<br>Data |                    | Member Flag                | - |                       |
| Member Contact -<br>Number    | 911111111          | Member Email Id            | - | JEENAJANAND@GMAIL.COM |

# Claim Details

| Nature Of Loss -    | Accompanying Persons<br>Expenses | Claim Type -                   |
|---------------------|----------------------------------|--------------------------------|
| Diagnosis -         | 0                                | Claim Reported In -<br>Days    |
| Date Of Admission - | 01-01-1900                       | Date Of Discharge - 01-01-1900 |

Number Of Days Hospitalised

-

-

-

-



Hospital Code

Name Of Hospital -

No Of Beds

Address Of Hospital Rohini Code

-

-

-

-

Hospital Type

Hospital Flag

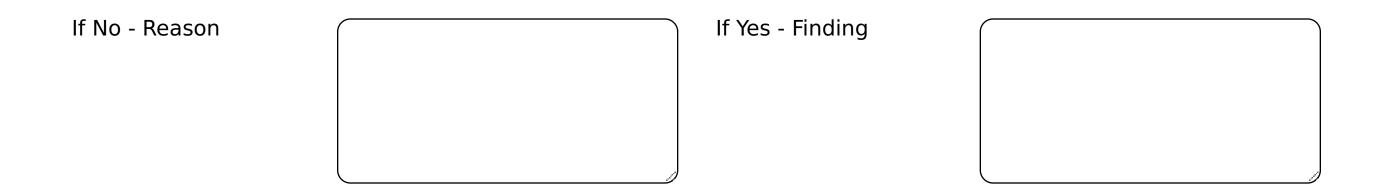
Location Of Hospital

|      |         | <b>—</b> • • |
|------|---------|--------------|
| (1)  | Trigger | Doint        |
| lain |         | POINT        |
|      |         |              |
|      |         |              |

Trigger 1 Auto Remark

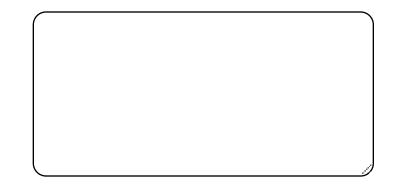
| Home Visit          |                         |                                                                   |            |
|---------------------|-------------------------|-------------------------------------------------------------------|------------|
| Visit done          | n Yes n No              | lf No - Reason                                                    |            |
| lf Yes - Visit Date |                         | Appointment Taken                                                 | □Yes □ No  |
| lf No - Reason      |                         | If Yes - Name of<br>insured with whom<br>appointment was<br>taken |            |
| Mobile no           |                         | Member Address                                                    |            |
| Name of Patient     |                         | Date of Birth of<br>Patient                                       |            |
| Gender              | O Male O Female O Other | Statement Collected                                               | 🗆 Yes 🗖 No |





#### Any discrepancies 🗆 Yes 🗖 No

lf No - Reason



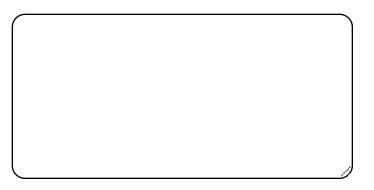
Any PED / Non-Disclosure findings

### Insured Habits

Past documents collected

🗆 Yes 🗖 No

lf No - Reason



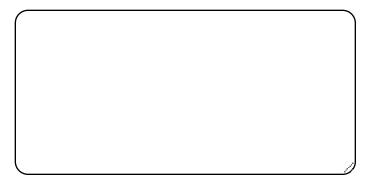
If Yes – please specify

KYC Documents collected

🗆 Yes 🗖 No

lf No - Reason

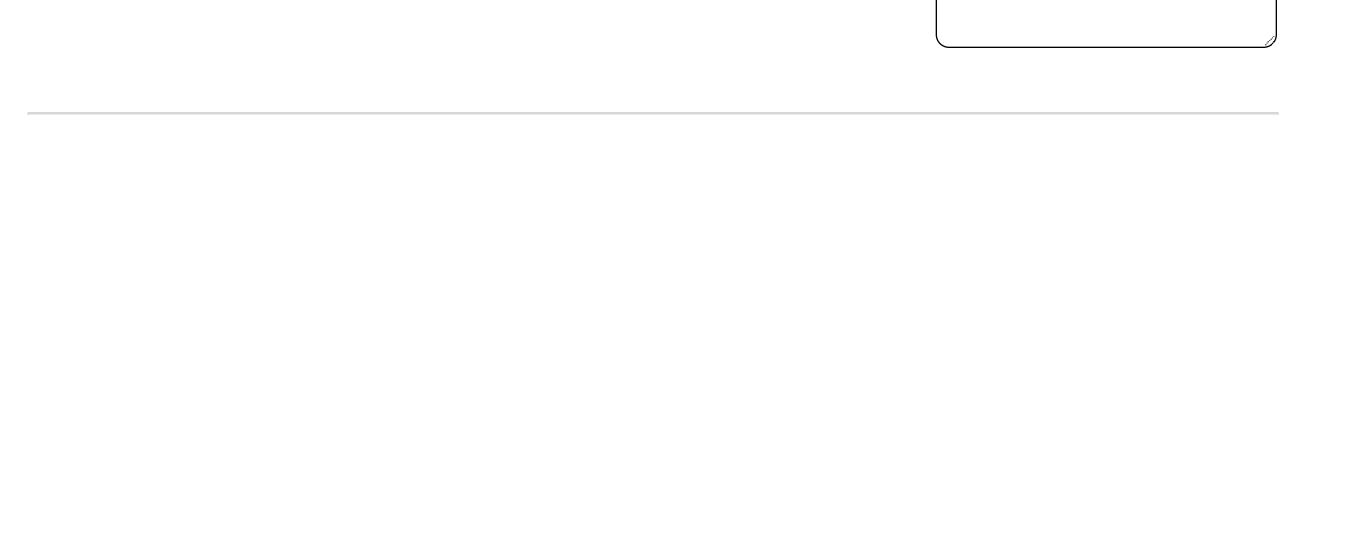
If No - Reason



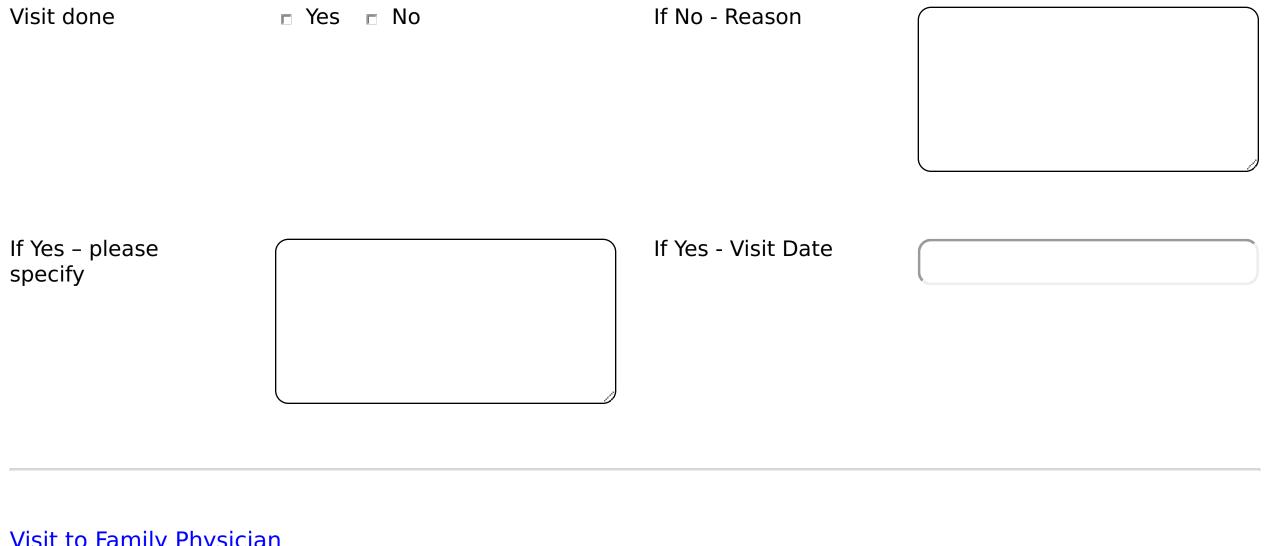
If Yes

Matching with Claim Document

Not Matching with Claim
Document

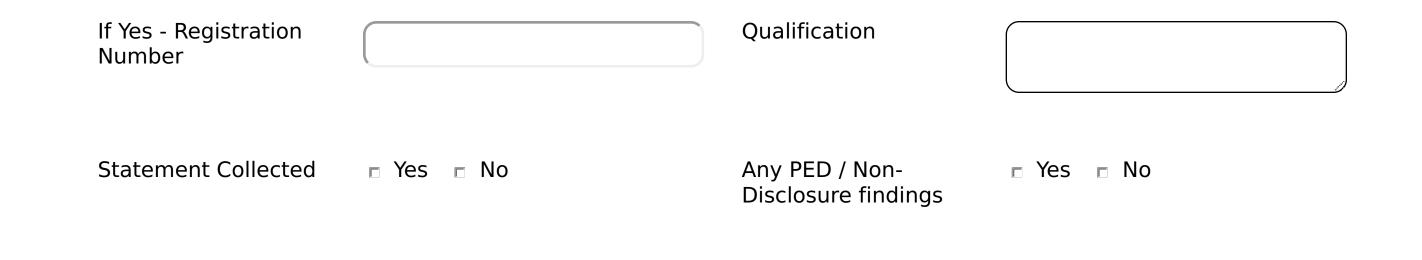


# Vicinity verification



# Visit to Family Physician

| Name of Family<br>Physician  |            | Location                      |  |
|------------------------------|------------|-------------------------------|--|
| Contact number               |            | Distance from<br>Insured Home |  |
| Visit to Family<br>Physician | □ Yes □ No | if No - Reason                |  |



# In Cases of First Consultant / Referral doctor

| Name of Family<br>Physician     |            | Location                              |            |
|---------------------------------|------------|---------------------------------------|------------|
| Contact number                  |            | Distance from<br>Insured Home         |            |
| Visit to Family<br>Physician    | n Yes no   | if No - Reason                        |            |
| lf Yes - Registration<br>Number |            | Qualification                         |            |
| Statement Collected             | r Yes r No | Any PED / Non-<br>Disclosure findings | □ Yes □ No |