

CLAIM FORM FOR HOSPITALIZATION REIMBURSEMENT BENEFIT FOR AXIS MAX LIFE GROUP SMART HEALTH INSURANCE PLAN

CLAIM FORM - PART A

The issue of this form is not to be taken as an admission of liability			
To 1	he filled in block letters)		
SECTION A – DETAILS OF PRIMARY INSURED	be filled in block letters)		
Management (Management (Manage			
Unique ID/Certificate of Insurance Number/Employee ID/Member Enrolment Number:			
Company/TPA ID No.:			
Name:			
Address:			
City: State:			
Pin code: Phone No.:			
Threade.			
E-mail ID:			
SECTION B - OTHER INSURANCE HISTORY			
Policy No. Company Name Sum Assured Status (Active/Lapsed/Applied/Matured)) Claim Status		
SECTION C - DETAILS OF INSURED PERSON HOSPITALISED			
a) Name:			
b) Gender: Male Female Transgender c) Date of Birth:			
e) Occupation: Service Self-employed Homemaker Student Other			
Please specify:			
f) Address (if different from above):			
City: State:			
Pin code: Phone No.: Phone No.:			
E-mail ID:			
SECTION D - DETAILS OF HOSPITALIZATION			
a) Name of the Hospital where admitted: b) Room category occupied: ICU Non-ICU			
c) Hospitalization due to: Illness Injury Investigation			
d) Date of Injury/Date of disease first detected/Date of delivery: DD MM YYYYY			
e) Date of admission: DD MM YYYYY f) Time of admission: H			
g) Date of discharge: DDDMMYYYYYY h) Time of discharge: H	JH:MMM		
i) If injury, give cause: Self-inflicted Road traffic/other accident Substance abuse/alcohol abuse			
i) If Medico legal: Yes No ii) Reported to police: Yes No			
j) Type of Treatment: Allopathy Others			
If Others, please specify	<u> </u>		

	SECTION E - DETAIL	S OF CLAIM	
a) Details of the treatment expe	enses claimed	iv) Claim documents submitted check list:	
i) Hospitalization period:	Duly filled and signed claim form		
Days ICU	Non ICU	Copy of intimation letter, if any	
		Hospital main bill	
b) Details of lump sum/cash ber			
i) Fixed daily Hospital cash	Rs	Hospital bill payment receipt	
ii) Surgical benefit	Rs	Hospital discharge summary	
iii) Critical illness benefit	Rs.	Pharmacy bill	
		Operation theater notes	
		Doctor's request for investigation	
		Doctor's prescription	
		All investigation reports including ECG, CT, MRI/USG/HPE)	
		KYC of LA and/or Nominee	
		(Personalized cancelled cheque, Passbook/PAN)	
		In case of accident, copy of first Information Report	
SEC	TION G - DETAILS OF PRIMARY I	NSURED'S BANK ACCOUNT	
a) PAN:	b) Account Numb	er:	
c) Bank name/Branch:			
d) Payable details: Cheque/DD:		e) IFSC Code:	
d) Fayable details. Cheque, DD.	SECTION H - DECLARATION		
I be a selected and a select the a forface of			
		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 voluntarily provide my consent to use my Aadhar to conduct identity check towards KYC compliance by Axis Max Life			
Lyoluntarily provide my concer		entity check towards KVC compliance by Avic May Life	
I voluntarily provide my consei Insurance.	nt to use my Aadhar to conduct id	entity check towards KYC compliance by Axis Max Life	
Insurance.	nt to use my Aadhar to conduct id	entity check towards KYC compliance by Axis Max Life	
Insurance. Date: DD MM YY	YY		
Insurance.	YY	entity check towards KYC compliance by Axis Max Life e of Insured/Nominee:	
Insurance. Date: DD MM YY Place:	Y Y Signature		
Insurance. Date: DD MM YY Place:	Signature E FOR FILLING CLAIM FORM - P. DESCRIPTION	ART A (To be filled in by the Insured) FORMAT	
Insurance. Date: DD MM YY Place: GUIDANC DATA ELEMENT	Signature E FOR FILLING CLAIM FORM - P DESCRIPTION SECTION A - DETAILS OF P	ART A (To be filled in by the Insured) FORMAT	
Insurance. Date: DD MM YY Place: GUIDANC DATA ELEMENT a) Unique ID/Certificate of	Signature E FOR FILLING CLAIM FORM - P. DESCRIPTION	ART A (To be filled in by the Insured) FORMAT	
Insurance. Date: DDMMYY Place: GUIDANC DATA ELEMENT a) Unique ID/Certificate of Insurance No./Employee	Signature E FOR FILLING CLAIM FORM - P DESCRIPTION SECTION A - DETAILS OF P	ART A (To be filled in by the Insured) FORMAT	
Insurance. Date: DD MM YY Place: GUIDANC DATA ELEMENT a) Unique ID/Certificate of Insurance No./Employee ID/Member Enrolment No.	Signature E FOR FILLING CLAIM FORM - P DESCRIPTION SECTION A - DETAILS OF P Enter the policy number	ART A (To be filled in by the Insured) FORMAT	
Insurance. Date: DDMMYY Place: GUIDANC DATA ELEMENT a) Unique ID/Certificate of Insurance No./Employee ID/Member Enrolment No. b) Company TPA ID no.	Signature E FOR FILLING CLAIM FORM - P DESCRIPTION SECTION A - DETAILS OF P Enter the policy number Enter the TPA ID no.	ART A (To be filled in by the Insured) FORMAT RIMARY INSURED	
Insurance. Date: DD MM YY Place: GUIDANC DATA ELEMENT a) Unique ID/Certificate of Insurance No./Employee ID/Member Enrolment No. b) Company TPA ID no. c) Name	Signature E FOR FILLING CLAIM FORM - P DESCRIPTION SECTION A - DETAILS OF P Enter the policy number Enter the TPA ID no. Enter the full name of the Policyh	ART A (To be filled in by the Insured) FORMAT RIMARY INSURED	
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Insurance. Date: DD MM YY Place: GUIDANC DATA ELEMENT a) Unique ID/Certificate of Insurance No./Employee ID/Member Enrolment No. b) Company TPA ID no. c) Name	Signature E FOR FILLING CLAIM FORM - P DESCRIPTION SECTION A - DETAILS OF P Enter the policy number Enter the TPA ID no. Enter the full name of the Policyh Enter the full postal address SECTION B - DETAILS OF INS	ART A (To be filled in by the Insured) FORMAT RIMARY INSURED older <surname, first="" middle="" name="" name,=""> SURANCE HISTORY</surname,>	
Insurance. Date: DD MM YY Place: GUIDANC DATA ELEMENT a) Unique ID/Certificate of Insurance No./Employee ID/Member Enrolment No. b) Company TPA ID no. c) Name	Signature E FOR FILLING CLAIM FORM - P DESCRIPTION SECTION A - DETAILS OF P Enter the policy number Enter the TPA ID no. Enter the full name of the Policyh Enter the full postal address SECTION B - DETAILS OF INS	ART A (To be filled in by the Insured) FORMAT RIMARY INSURED older <surname, first="" middle="" name="" name,=""> SURANCE HISTORY d by</surname,>	
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Insurance. Date: DD MM YY Place: GUIDANC DATA ELEMENT a) Unique ID/Certificate of Insurance No./Employee ID/Member Enrolment No. b) Company TPA ID no. c) Name d) Address	Signature E FOR FILLING CLAIM FORM - P DESCRIPTION SECTION A - DETAILS OF P Enter the policy number Enter the TPA ID no. Enter the full name of the Policyh Enter the full postal address SECTION B - DETAILS OF INS Indicate whether currently covere another Mediclaim/Health insural Enter the date of commencement	ART A (To be filled in by the Insured) FORMAT RIMARY INSURED SURANCE HISTORY d by nce of first insurance D D M M Y Y Y Y	
Insurance. Date: DD MM YY Place: GUIDANC DATA ELEMENT a) Unique ID/Certificate of Insurance No./Employee ID/Member Enrolment No. b) Company TPA ID no. c) Name d) Address e) Company name	Signature E FOR FILLING CLAIM FORM - P DESCRIPTION SECTION A - DETAILS OF P Enter the policy number Enter the TPA ID no. Enter the full name of the Policyh Enter the full postal address SECTION B - DETAILS OF INS Indicate whether currently covere another Mediclaim/Health insurant Enter the date of commencement Enter the full name of the insurant	ART A (To be filled in by the Insured) FORMAT RIMARY INSURED SURANCE HISTORY d by nce of first insurance D D M M Y Y Y Y	
Insurance. Date: DD MM YY Place: GUIDANC DATA ELEMENT a) Unique ID/Certificate of Insurance No./Employee ID/Member Enrolment No. b) Company TPA ID no. c) Name d) Address e) Company name Policy no.	Signature E FOR FILLING CLAIM FORM - P DESCRIPTION SECTION A - DETAILS OF P Enter the policy number Enter the TPA ID no. Enter the full name of the Policyh Enter the full postal address SECTION B - DETAILS OF INS Indicate whether currently covere another Mediclaim/Health insuran Enter the full name of the insuran Enter the policy number	ART A (To be filled in by the Insured) FORMAT RIMARY INSURED SURANCE HISTORY d by nce of first insurance ce company	
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Insurance. Date: DD MM YY Place: GUIDANC DATA ELEMENT a) Unique ID/Certificate of Insurance No./Employee ID/Member Enrolment No. b) Company TPA ID no. c) Name d) Address e) Company name Policy no. Sum Insured	Signature E FOR FILLING CLAIM FORM - P DESCRIPTION SECTION A - DETAILS OF P Enter the policy number Enter the TPA ID no. Enter the full name of the Policyh Enter the full postal address SECTION B - DETAILS OF INS Indicate whether currently covere another Mediclaim/Health insuran Enter the date of commencement Enter the full name of the insuran Enter the policy number Enter the Total Sum Insured as pe ECTION C - DETAILS OF INSURED	ART A (To be filled in by the Insured) FORMAT RIMARY INSURED Older	
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Insurance. Date: DD MM YY Place: GUIDANC DATA ELEMENT a) Unique ID/Certificate of Insurance No./Employee ID/Member Enrolment No. b) Company TPA ID no. c) Name d) Address e) Company name Policy no. Sum Insured S a) Name b) Gender c) Age	E FOR FILLING CLAIM FORM - P. DESCRIPTION SECTION A - DETAILS OF P. Enter the policy number Enter the full name of the Policyh Enter the full postal address SECTION B - DETAILS OF INS Indicate whether currently covere another Mediclaim/Health insuran Enter the full name of the insuran Enter the policy number Enter the Total Sum Insured as per ECTION C - DETAILS OF INSURED Enter the full name of the Patient Indicate gender of the Patient Enter completed age of the Patier	ART A (To be filled in by the Insured) FORMAT RIMARY INSURED Older SURANCE HISTORY d by nce of first insurance p p M M Y Y Y Y r the policy PERSON HOSPITALIZED	
Insurance. Date: DD MM YY Place: GUIDANC DATA ELEMENT a) Unique ID/Certificate of Insurance No./Employee ID/Member Enrolment No. b) Company TPA ID no. c) Name d) Address e) Company name Policy no. Sum Insured S a) Name b) Gender	E FOR FILLING CLAIM FORM - PODESCRIPTION SECTION A - DETAILS OF PODESCRIPTION SECTION A - DETAILS OF PODESCRIPTION Enter the policy number Enter the full name of the Policyh Enter the full postal address SECTION B - DETAILS OF INSUME Indicate whether currently covered another Mediclaim/Health insurant Enter the date of commencement Enter the full name of the insurant Enter the policy number Enter the Total Sum Insured as per ECTION C - DETAILS OF INSURED Enter the full name of the Patient Indicate gender of the Patient	ART A (To be filled in by the Insured) FORMAT RIMARY INSURED Older	

DATA ELEMENT	DESCRIPTION	FORMAT
f) Address	Enter the full postal address	
g) Phone no.	Enter the phone number of Patient/LA	
h) E-mail ID	Enter E-mail address of Patient/LA	
	SECTION D - DETAILS OF HOSPITALIZATION	ĺ
a) Name of Hospital where admitted	Enter the name of hospital	
b) Room category occupied	Indicate the room category occupied	
c) Hospitalization due to	Indicate reason of hospitalization	
d) Date of injury/Date of disease first detected/ Date of delivery	Enter the relevant date	DD MM YYYY
e) Date of admission	Enter date of admission	DDMMYYYY
f) Time	Enter time of admission	HH:MM
g) Date of discharge	Enter date of discharge	DD MM YYYY
h) Time	Enter time of discharge	H H: M M
i) If injury give cause If medico legal Reported to police	Indicate cause of injury Indicate whether injury is medico legal If yes, MLC report and FIR/DD Entry to be attached	Yes No No No
j) System of medicine	Enter the system of medicine followed in treating the Patient	
	SECTION E - DETAILS OF CLAIM	
a) Details of treatment expenses	The second secon	
 c) Details of lump sum/cash benefit claimed 	Enter the amount claimed as lump sum/cash benefit	
d) Claim documents submitted check list	Indicate which supporting documents are submitted	
Indicate which bills are enclosed	d with the amounts in rupees	du.
SEC	CTION G - DETAILS OF PRIMARY INSURED'S BANK	ACCOUNT
a) PAN	Enter the permanent account number	
b) Account number	Enter the bank account number	
c) Bank name and branch	Enter the bank name along with the branch	
d) Cheque/DD payable details	Enter the name of the beneficiary the	
	cheque/DD should be made out to	
e) IFSC code	Enter the IFSC code of the bank branch	



CLAIM FORM FOR HOSPITALIZATION REIMBURSEMENT BENEFIT FOR AXIS MAX LIFE GROUP SMART HEALTH INSURANCE PLAN

CLAIM FORM - PART B TO BE FILLED IN BY THE HOSPITAL			
DETAILS OF HOSPITAL			
a) Name of hospital: b) Hospital ID: c) Type of hospital: Network	Non-network If no	on-network, fill section E	
d) Name of the treating doctor:			
e) Specialization:	f) Registration	on no. with state code:	
g) Phone no.:			
	DETAILS OF THE P	ATIENT ADMITTED	
a) Name of the Patient: b) Registration no.:		c) Gender: Male Fema	
d) Age: Years Months		-,	MYYYY
f) Date of admission: D D M	MYYYY	g) Time of admission: H H:	MM
,	M Y Y Y Y	i) Time of discharge: HH:	MM
j) Type of admission: Planned Day care k) If maternity: i) Date of delivery: DDMMYYYY ii) Gravida status:			
k) If maternity: i) Date of delivery:l) Status at time of discharge: Discl	DID MM YYYY		eceased
ij Status at time of discharge. Disch		DIAGNOSED (PRIMARY)	ccascu
a) ICD 10 Codes	Description	b) ICD 10 PCS	Description
i) Primary diagnosis		i) Procedure 1	7107
ii) Additional diagnosis		ii) Procedure 2	
iii) Co-morbidities:		iii) Procedure 3	
iv) Co-morbidities		iv)) Procedure 4	
c) Present ailment is a complication	of Pre-existing? Yes	No If Yes, specify deta	nils:
f) Hospitalization due to injury: Yes	No No		
i) If Yes, give cause: Self-inflicted Road traffic accident Substance abuse/alcohol consumption			
ii) If Injury due to substance abuse/alcohol consumption, test conducted to establish this: Yes No			
iv) Reported to police: Yes No v) FIR no.			
vi) If not reported to police give reasons			
CLAIM DOCUMENTS SUBMITTED CHECK LIST			
Claim form duly signed		All Investigation reports in	Marie Say Marie Land
Copy of photo ID card of Patien	t verified by hospital	(CT/MRI/USG/HPE/ECG e	etc.)
Hospital discharge summary		Pharmacy bills	analized cancelled shears
Operation theatre notes		passbook, PAN, Aadhar)	onalized cancelled cheque/
Hospital main bill			
Hospital break-up bill			

DETAILS IN CASE OF NON-NETWORK (ONLY I	FILL IN CASE OF NON-NETWORK HOSPITAL)	
a) Address of hospital: b) City: d) Pin code: f) Registration no.: h) Number of in-patient beds ii) ICU: Yes No iii) Others DECLARATION BY THE INSURED (C) State: e) Phone no.: g) PAN: ole in the hospital: i) OT: Yes No	
I hereby declare that the information furnished in this 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, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA I 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 voluntarily provide my consent to use my Aadhar to conduct identity check towards KYC compliance by Axis Max Life Insurance. Date:		
Place: Signa	ature of Insured/Nominee:	
DECLARATION B	THE HOSPITAL	
We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Claim Form B is fully filled up by us. Date: Diminished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Claim Form B is fully filled up by us. Date: Diminished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Claim Form B is fully filled up by us. Date: Diminished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.		
CHECK LIST OF ENCLOSURES	FOR SUBMISSION OF CLAIM	
In-Patient treatment /day care procedures Duly filled and signed claim form Photocopy of ID card/photocopy of current year policy Copy of detailed discharge summary with date of admission & discharge, clinical history, past history/procedure details/day care summary from the hospital Copy of consolidated hospital bill with break up of each item, duly signed by the insured. Payment receipt of the hospital bill. Road traffic accident In addition to the In-Patient treatment documents: Copy of the First Information Report from police	Payment receipt of the hospital bill First consultation letter and subsequent prescriptions Copy of bills, copy of payment receipts and reports for investigation Copy of medicine bills and receipts with corresponding prescriptions Copy of invoice/sticker of implants/bills for Implants (viz. Stent/PHS mesh/IOL, etc) with payment receipts In Non Medico legal cases Treating doctor's certificate giving details of injuries (how, when and where injury sustained)	
department/copy of the Medico-Legal certificate.	OLIDE (AS DED VVC NODMS OF IDDA)	
CUSTOMER IDENTIFICATION PROCEI Please submit the following documents in	case of claim amount exceeds Rs. 100,000	
Legal name and any other names used (Any one of the mentioned documents)	Passport/PAN card/voter's identity card/driving license/ letter from a recognized public authority or public servant verifying the identity and residence of the customer	
Proof of residence (Any one of the mentioned documents)	Telephone bill/bank account statement/letter from any recognized public authority/electricity bill/ration card	
NOTE: Please send the documents to TPA office on below address or email the documents to the email id given below: TPA Name: MD India Health Insurance TPA Pvt. Ltd. Address: S. No. 46/1, E-space, A-2 Building, 2nd Floor, Pune Nagar Road, Vadgaonsheri, Pune 411014. Email ID: customercare@mdindia.com, Toll Free No.: 1800 210 6862, Website: www.mdindiaonline.com		
	gin to manage your policy cismaxlife.com/customer-service Call us at 1860 120 5577 f X @ •	
Axis Max Life Insurance Limited (formerly known as Max Life Insurance Company Limited) is a Joint Venture between Max Financial Services Limited and Axis Bank Limited. Important: DO NOT believe in calls, SMSes or e-mails offering discounts. For NEFT Payments, please transfer only to "Axis Bank A/C No. 7408 <followed 8="" by="" digit="" group="" no.="" policy=""> IFSC Code: UTIB0000131". Axis Max Life Insurance does not collect Premium in any other account. Axis Max Life Insurance Limited (formerly known as Max Life Insurance Company Limited): Plot No. 90 C, Sector 18, Udyog Vihar, Gurugram, Haryana - 122 015. Regd. Office: 419, Bhai Mohan Singh Nagar, Railmajra, Tehsil Balachaur, District Nawanshahr, Punjab - 144 533. CIN: U74899PB2000PLC045626 Customer Helpline Number: 1860 120 5577 The Brand Ambassadors (if depicted herein), have endorsed only the Axis Max Life Insurance Products and are not in any manner endorsing Axis Bank Limited and do not have any kind of association or relationship with Axis Bank Limited. IRDAI Registration No. 104</followed>		
BEWARE OF SPURIOUS/FRAUD PHONE CALLS! IRDAI is not involved in activities like selling insurance policies, announcing bonus or investment of premiums Public receiving such phone calls are requested to lodge a police complaint		