The New India assurance Company Limited

Registration & Office : New India Assurance Building, 87 m.g. Road Fort, Bombay-400001

HOSPITALISATION AND DOMICIALIARY HOSPITALISATUION BENEFIT POLICY

CLAIM FORM

CLAIM NO. □/□□ /□□/□/□□□□□/□ □

Issuance of this form does not amount to admission of any liability under the claim on the part of the insurers

Please give the following information correctly and completely to enable the Company to process your claim promptly. If the claim is under personel accident insurance, please complete a Personel accident claim form.

FOR OFFICE USE ONLY

1. Name of the Insured : □□□□□□□□□□□□ □□□□□
   (in whose name policy is issued) SURNAME INITIALS
2. Details of the insured person
   (in respect of whom claim is made)
   (a) Name & relationships to the Insured :
   (b) Present Completed Age :
   (c) Occupation :
   (d) Residential address : …….
   …….
   …….
3. Policy
4. Nature of Disease/illness contracted o injury suffered : …….
5. Date of injury sustained or Disease/illness first Detected :
6. (a) Name & address of the attending Medical Practition …….
   …….
   Pin Code …….
   State/U. Territory ……
   (b) Qualification & Telephone No :
   (c) Registration No. : □□□□
7. I. (a) Name & Address of the Hospital/Nursing : …….
   Home/Clinic : …….
   Pin Code …….
   State/U. Territory ……
   (b) Date of Addmission : □□ □□ □□
   Date Month Year
   (c) Date of Discharge □□ □□ □□
   Date Month Year
   II. If the claims is for Domiciliary Hospitalisation
   Please indicate
   (a) Date of Commencement of treatment □□ □□ □□
   Date Month Year

(b) Date of Completion of treatment

□□ □□ □□

Date Month Year

(c) Name & Address of attending Medical Practitioner : …….
…….
Pin Code …….
State/U. Territory ……

(d) Telephone No.

(e) Registration No. □□□□□

Are you at present covered under any other similar type of scheme like P.A., cancer Insurance, Mediclaim (Individual or Group). Health Insurance etc. If so, give particular of each

1. Name of the Insured : □□□□□□□□□□□□□□□□□□□□

2. Policy No. □□□□□□□□□□□□□□□□□□□□

3. Scheme

4. Period of Coverage

I have incurred on the treatment of Disease/illness/Accident referred to above, the expenses as per the details given by me in the Schedule of Expenses given overleaf.

In supported of the above claim. I enclose the following documents (Please indicate by ✓) :-

1. Bill, Receipt and discharge certificate/card the Hospital.
2. Cash Memos from the Hospital/Chemist(s), supported by the proper prescription.
3. Receipt and Pathological test report form a Pathologist supported by the note from the attending medical Practitioner/ Surgeon demanding such Pathological tests.
4. Surgeon's certificate stating nature of operation performed and surgeons bill and receipt.
5. Attending Doctor's /Consultant's /Specialists/Anesthetist's bill and receipt and certificate regarding diagnosis.
6. In case of Domiciliary Hospitalisation, receipt from a qualified nurse who attended the patient at his/her residence duly supported by a certificate from attending Medical Practitioner.
7. Certificate from the attending Medical Practitioner giving reasons for allowing treatment at home.
8. Certificate from the attending Medical Practitioner/Surgeon that the Patient is fully cured.

I hereby warrant the truth of the foregoing particulars in every respect and I agree that it I have made or shall make any false or untrue statement, suppression or concealment,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 admissible under any other Medical Scheme or Insurance.

Date……this……day of ……200

Signature of Claimant

FOR OFFICE USE

Date of Claim □□□□□□