RELIANCE
General Insurance

1800 3002 8282 (toll free)
022 3989 8282 (charges apply)
www.reliancegeneral.co.in

Reliance Individual Mediclaim Policy

Claim Form

Issuance of this form does not imply acceptance of the liability

(To be filled in BLOCK LETTERS)

Please answer all questions fully. Please attach all bills, receipts and credit card slips pertaining to your claim.

1. Name of the Insured (in whose name the policy is issued)

2. Policy No.

   Period of Insurance d d m m y y y y to d d m m y y y y

   Sum Insured

3. Address of the Insured

   Plot No./Door No. Building Name

   Road/Street/Sector

   Area

   Taluka/Village/District/City Pin Code

   State Country

   Telephone Mobile

   E-mail

4. Name of the Insured Person (in respect of whom the claim is made)

   Relationship with the Insured

   Present completed age

   Occupation

5. Date of injury sustained or disease/illness first detected d d m m y y y y

6. Please describe the injury sustained or disease/illness contracted (including cause)

7. Name of the attending Medical Practitioner

   Dr.

   Address of the attending Medical Practitioner

   Plot No./Door No. Building Name

   Road/Street/Sector

   Area

   Taluka/Village/District/City Pin Code

   State Country

   Telephone Mobile

   E-mail Fax

   Qualification

   Registration no.

8. Name of the Hospital/Nursing Home

Address of the Hospital/Nursing Home

Plot No./Door No. Building Name

Road/Street/Sector

Area

Taluka/Village/District/City Pin Code

State Country

Telephone Fax

E-mail

9. Date of admission d d m m y y y y 10. Date of discharge d d m m y y y y

11. Date and mode of intimation given to the TPA d d m m y y y y m o d e

If TPA not intimated, please provide reasons for the same

12. If the claim is for Domiciliary Hospitalisation, please indicate

Date of commencement of treatment d d m m y y y y

Date of completion of treatment d d m m y y y y

Name of attending Medical Practitioner. Is it same as mentioned under point 7. ☐ Yes ☐ No

Dr.

If No, address of attending Medical Practitioner

Plot No./Door No. Building Name

Road/Street/Sector

Area

Taluka/Village/District/City Pin Code

State Country

Telephone No. Fax

Registration No.

13. Have the Police Authorities been informed? ☐ Yes ☐ No
(For accident case only)

14. Are you at present covered under any other similar type of schemes like Personal Accident, Cancer Insurance, Mediclaim (Individual or Group), Health Insurance, etc? If Yes, please give particulars of the Policy Type/Policy No./Insurance Company

Is this the first year of coverage under any Health Insurance Policy? ☐ Yes ☐ No

If NO, since when have you been continuously Insured under any Health Insurance Policy. Please provide the necessary details (Policy No., etc.)?

15. Schedule of expenses incurred under the following benefits (to be supported by original bills/receipts, cash memos etc.) Please refer your Policy for coverage details. In case of insufficient space, please attach an additional sheet.

a. Hospitalisation _____

b. Day Care Treatment _____

c. Pre Hospitalisation _____

d. Post Hospitalisation _____

e. Ambulance Charges _____

f. Domiciliary Hospitalisation _____

g. Heath checkup Expenses _____

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 information, my right to claim reimbursement of the said expenses shall be absolutely forfeited.

I also consent & authorise the THIRD PARTY ADMINISTRATOR to seek medical information from any Hospital/Nursing Home/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/Nursing Home on my behalf for full and final settlement of Hospital/Nursing Home bills.

I hereby authorise any Hospital/Nursing Home, Physician, or other person who has treated attended or examined me, to furnish to the Company, or its authorised representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment including copies of relevant hospital or medical records, a photostat copy of this authorisation shall be considered as effective and valid as the original.

_____

Signature of the Insured/Insured Person

Date: _____

Place:_____

Document check list for health:

Documents to be attached while claiming under the following sections:

Hospitalisation/Day Care Treatment

1. First prescription of doctor with commencement date of the symptom of disease.
2. Treatment papers along with doctors prescriptions.
3. Investigation reports (X-ray/Scan/ECG, Laboratory etc).
4. Original medical bills and receipt of hospital, doctors, medical shops, diagnostic centre etc supported by doctor's advice.
5. Hospital discharge card.
6. Copy of FIR (in case of accident).

Domiciliary Hospitalisation

1. First prescription of doctor with commencement date of the symptom of disease.
2. Treatment papers along with doctors prescriptions.
3. Investigation reports (X-ray/Scan/ECG, Laboratory etc).
4. Original medical bills and receipt of doctors, medical shops, diagnostic centre etc supported by doctor's advice.
5. Copy of FIR (in case of accident).
6. Certificate from attending doctor/physician stating the condition of the patient is not permissible for him/her to be removed to hospital/nursing home or documentary proof of lack of accommodation in hospital/nursing home

Attending Medical Practitioner's Statement

To be answered by attending Medical Practitioner in complete.
(To be filled in case discharge summary does not contain the following information)

1. Name of the Insured (in respect of whom the treatment is given)

2. Age

3. Address of the Insured

Plot No./Door No. Building Name

Road/Street/Sector

Area

Taluka/Village/District/City Pin Code

State Country

Telephone Mobile

E-mail

4. Nature of the disease suffered by Insured

5. What treatment was given/operations performed, if any?

6. When did the first symptom appear? d d m m y y y y

7. Whether the present ailment is pre-existing or caused by any pre-existing ailment? If Yes, please specify

For accident case:

8. Are the injuries traceable to any pre-existing ailment/infirmities?

9. Was he/she under the influence of intoxicants or drugs at the time of accident?

10. Any medico legal case filed?

11. Have you provided medical treatment to the Insured previous to this treatment? If YES, specify time since when you have been attending him/her?

12. If you have treated him/her for any previous illness or injury, please give details

Signature of the Medical Practitioner

Date:

Name Dr.

Regn. No.

Address of the Doctor

Plot No./Door No. Building Name

Road/Street/Sector

Area

Taluka/Village/District/City Pin Code

State Country

Telephone Mobile

E-mail Fax