The New India Assurance Company Limited

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

Claim Number

HOSPITALISATION AND DOMICILIARY HOSPITALISATION BENEFIT POLICY

CLAIM FORM

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. If the claim is under Personal Accident Insurance, please complete a Personal Accident Claim Form.

All dates to be entered as Date / Month / Year

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 & Relationship with the Insured :_____
   (b) Present Completed Age :_____
   (c) Occupation :_____
   (d) Residential Address :_____
   _____
   _____
3. Policy Number (in Full) :
4. Nature of Disease/Illness contracted or injury sustained :_____
5. Date on which injury was sustained/Disease
   Or illness 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_____
   (b) Date of Admission :_____
   (c) Date of Discharge :_____
8. If the Claim is for Domiciliary Hospitalisation,
   Please indicate :_____

(a) Date of Commencement of treatment :_____

(b) Date of Completion of treatment :_____

(c) Name & Address of attending Medical Practitioner :_____

:_____

Pin Code_____

State / U. Territory_____

(d) Telephone No. :_____

(e) Registration No. :_____

9. 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 Yes. Please give particulars of each

(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

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

(ii) If no, please quote Previous claim number and details

In support of the above claim, I enclose the following original documents (Please indicated 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.
4. Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.
5. Attending Doctor's/ Consultant's/ Specialist's / 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 attending Medical Practitioner giving reasons for allowing treatment at home.
8. 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	Rs. _____
Grand Total	Rs. _____

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, 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.

I ALSO CONSENT AND AUTHORISE THE 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 insurance company as reimbursement of hospital bills incurred on my treatment.

Dated at……. this…… day of……2003

Signature of the Claimant

ECS Details of the Insured

1	Name of the Insured (as appearing in the Bank Account)	
2	Bank Name	
3	Branch and address	
4	Bank Account No.	
5	Bank Account Type	
6	IFSC Code	
7	MICR Code	