UNITED INDIA INSURANCE COMPANY LIMITED

Reg. & Head Office: 24, Whites Road, Chennai - 14.
BRANCH / DIVISIONAL OFFICE.....

CLAIM FORM FOR HEALTH INSURANCE POLICY 2010

Policy No. Claim No.

Issue 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.

1	a) Name of the Insured (Name in full) b) Address c) Occupation	
2	Details of Insured Person: a) Name of the person in respect of whom the claim is made. b) Relationship to the Insured c) Present completed age d) Occupation e) Residential address.	
3	**Details of Hospitalisation**: a) Name of the Insured person (in respect of whom claim is made) b) Present completed age c) Nature of Disease / Illness contracted or injury sustained d) Date of injury sustained or disease/ illness first detected e) Name and address of the Hospital / Nursing Home f) Date of Admission g) Date of Discharge h) Details of expenses	a) b) c) d) e) f) g) h)

SCHEDULE OF HOSPITALISATION EXPENSES INCURRED			FOR OFFICE USE	
Details of expenses claimed for Hospitalisation (to be supported by Bills, Receipts, Cash Memos along with discharge summary)		Amount Claimed Rs	Amount eligible Rs	Amount Admissible Rs.
a)	Hospitalisation: a) Room Board, Nursing Expenses for days @Rs. per day b) I.C.U charges for days @ Rs.			

	per day			
b)	Non-Surgical & Surgical: a) Surgeon & Anaesthetist fees b) Medical Practitioners, Consultants and specialists fees for consultations No of visits c) Nursing expenses			
c)	a) Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical appliances. b) Diagnostic materials and X-Ray.,etc., c) Dialysis, Chemotherapy, Radiotherapy, Cost of peacemaker, Artificial Limbs & Cost of organs and similar expenses d) Medicines and Drugs i) Supplied by Hospital ii) Purchased from Chemists			
d)	Ambulance charges			
e)	Daily hospital cash			
f)	Amount of co pay applicable			
5	Details of other health insurance policies covering the above Insured Person			

I hereby declare that I have incurred on the treatment of Disease/Illness /Accident referred above, the expenses as per the details given by me. In support of this claim, I enclose all relevant bills vouchers and other documents.

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 and I shall rendered myself liable to any legal action.

Place:

Date: Signature of Insured Person Signature of Insured