Universal Sompo General Insurance Co. Ltd.

(A joint venture between Allahabad Bank, Sompo Japan Insurance Inc., Indian Overseas Bank, Karnataka Bank and Dabur Investments.)

Regd. Office: 201-208, Crystal Plaza, Opp. Infiniti Mall, Link Road, Andheri (West), Mumbai - 400 058.

HEALTH INSURANCE CLAIM FORM

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

a) Claim form is to be filled in capital letter & signed by the insured/beneficiary.
b) Please do not leave any column unanswered.
c) Please read carefully the attached list of documents required to speed up processing of your claim.
d) If there is insufficient space, kindly use a separate sheet which can be attached to this form.

Claim No.

A. DETAILS OF INSURED

Name of the Insured (in whose name policy is issued) — First Name | Middle Name | Last Name

Name of the Insured person (In respect whom claim is made) — First Name | Middle Name | Last Name

Relationship with Insured

Date of Birth Sex ☐ Male ☐ Female Email ID

Communication

Address

City/Taluka District State

Pin Code STD code Phone No. Mobile No.

B. DETAILS OF POLICY

Policy No. ☐☐☐ / ☐☐☐☐☐☐☐ / ☐☐ / ☐☐☐ Health card No.

Period of insurance from to Sum Insured

C. DETAILS OF OTHER POLICIES

Have you been insured under any Mediclaim scheme of any other insurance companies? ☐ Yes ☐ No
If "Yes", please enclose photocopies of all previous policies.

Date of commencement of very first insurance for the Beneficiary with continuous insurance coverage? from to

D. DETAILS OF PREVIOUS CLAIM

Have you incurred any claim of the same beneficiary earlier? If so give details. ☐ Yes ☐ No
Previous claim no.

Diagnosis

Date of admission Date of Discharge Paid ☐ Yes ☐ No Amount settled

Repudiated ☐ Yes ☐ No If Yes, reason for Repudiation

E. DETAILS OF INCIDENCE

Nature of disease, Illness, injury

Symptoms & Signs

Date of incidence

Date of admission Time of admission ☐☐:☐☐ AM/PM.

Date of discharge Time of discharge ☐☐:☐☐ AM/PM.

Type of admission ☐ Emergency ☐ Planned ☐ Day Care ☐ Domiciliary

F. DETAILS OF HOSPITAL

Name of the Hospital
Address

City/Taluka District State

Pin Code STD code Phone No. Mobile No.

G. DETAILS OF CURRENT CLAIM BILLS

	Expense Details	Amount (Rs.)
(A)	Pre-hospitalization expenses	
(B)	Hospitalization expenses	
(C)	Post-hospitalization expenses	
(D)	Day care hospitalization	
(E)	Daily hospital cash allowance	
(F)	Maternity expenses	
(G)	Domiciliary expenses	
	TOTAL AMOUNT CLAIMED	

Description	Bill Date	Bill No.	Bill Amount (Rs.)	Claimed Amount (Rs.)
Room rent				
Investigations				
Medicines				
Surgeon fees				
Anesthetist fees				
Operation theatre fees				
Consumables				
Consultation fees				
Ambulance expenses				
Other charges 1				
Other charges 2				
GRAND TOTAL				

H. ENCLOSURES

- ☐ Claim form duly signed
- ☐ Pre-authorization form
- ☐ Discharge summary
- ☐ Hospitalization bills
- ☐ Medicine bills
- ☐ Investigation bills
- ☐ Surgery/consultation fees
- ☐ Pre-hospitalization bills
- ☐ Post-hospitalization bills
- ☐ Doctor's prescription
- ☐ Medical certificate
- ☐ FIR/ MLC copy
- ☐ Investigation reports
- ☐ Any other documents

If "Yes", please specify _____

I. INSURED'S DECLARATION

I hereby warrant the truth of foregoing statement and sincerely declare that I have not suppressed or concealed any information that is material to this claim. I understand that false declaration/s may result in USGI being able to refuse to pay the claim.

I authorize any hospital, physician or any other medical provider who has attended me or examined me to furnish USGIC such details of my medical history/treatment as they may require.

Date: Signature of Insured:

Place: Name of the Insured:

J. ATTENDING MEDICAL PRACTIONER'S DECLARATION

I hereby certify that ______ was treated by me on ______ for ______

which first incurred on ______

The ailment was caused by / in any way associated with the below mentioned conditions;

Pregnancy or childbirth	☐ Yes ☐ No		Sterility	☐ Yes ☐ No
Cosmetic or aesthetics treatment	☐ Yes ☐ No		Correction of eye sight	☐ Yes ☐ No
Congenital deformities or anomalies	☐ Yes ☐ No		Mental disease	☐ Yes ☐ No
Intentional self injury	☐ Yes ☐ No		Use of Intoxicating drugs and alcohol	☐ Yes ☐ No
HIV, AIDS	☐ Yes ☐ No		Venereal disease or sexually Transmitted disease	☐ Yes ☐ No

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Name of the treating Medical Practitioner — First Name ______ Middle Name ______ Last Name ______

Registration No. ______ Qualification ______

Date: ______

Stamp and Signature of the Medical practitioner ______

Place: ______

*Applicable only for General Health Check up Claims

K. DETAILS OF GENERAL HEALTH CHECK-UP

Name of the Hospital ______

Address ______

City/Taluka ______ District ______

State ______ Pin Code ______

STD code ______ Phone No. ______ Email ID ______

Claim type ☐ Cashless ☐ Reimbursement

Description of tests carried out CBC, X-ray etc. ______

Date of check up ______ Amount claimed (Rs.) ______

I confirm that no claim has been made by my family members or me during the past four continuous policy periods nor any claim is proposed to be lodged for the same period.

Date: ______ Signature of Claimant: ______

Place: ______ Name of the Claimant: ______

L. DETAILS OF OTHER INFORMATION

Do you wish to provide any other information? ☐ Yes ☐ No

If "Yes", specify ______

I/We, the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect; and I/we agree that if I/We have made, or in any further declaration, the Company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited, and the Policy shall be null and void, and all rights to recover thereunder in respect of past or future loss/accidents shall be forfeited.

Date: ______ **Signature:** ______

Place: ______ **Name of Insured:** ______