THE NEW INDIA ASSURANCE CO. LTD.

87, M.G. ROAD, MUMBAI- 400 001.

CANCER MEDICAL EXPENSES INSURANCE POLICY

CLAIM FORM

The issue of this form by insurance company shall not be taken as an admission of liability.

Claim No.....

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

2. Details of insured person :
   (in respect of whom claim is made)

   a) Age
   b) Occupation
   c) Address

3. Policy No.

4. Nature of disease :

5. What were your first symptoms & date :

6. Date of first detection of disease :

7. (a) Name & address of the attending
   Medical Practitioner.
   (b) His qualifications & Telephone No.
   (c) Registration No.

8. (a) Name & address of the hospital /Nursing home/ Clinic.
   (b) Date of addmission
   (c) Date of discharge

9. Total amount of Claim Rs. .....

In support of the above claim, I enclose following documents (Please indicate by / tick) :-

1. Bill Receipt and Discharge certificate / card from the Hospital.

2. Cash Memos from the Hospital/ Chemist (s), supported by the proper prescription .

3. Receipt and Investigation reports from a Laboratory supported by the note form the attending Medical Practitioner/ Surgeon demanding such tests.

4. Surgeon's certificate stating nature of operation performed and Surgeon's bill and receipt .

5. Attending Doctor's/ Consultant's/ Specialist's/ Anaesthetist's bill and receipt and certificate regarding diagnosis.

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 .

Dated at _____ this _____ day of _____ 20

Signature of the Claimant

Place _____