RELIANCE
General Insurance

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

Reliance Critical Illness Policy
Claim Form

Issuance of this form does not amount to admission of any liability under the Policy on the part of the Company.
Please give the following information correctly and completely to enable us process your claim promptly.

To be filled in BLOCK LETTERS. Please answer all questions fully.

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

2. 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

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

Relationship with the Insured
Present completed age | Occupation

4. Policy No. (in full) | Sum Insured
Period of Insurance d d m m y y y y to d d m m y y y y

5. Nature of disease/illness contracted, injury sustained or surgery performed?

6. Is the disease/illness contracted or surgery performed due to any accident? ☐ Yes ☐ No
If YES, please provide the details of accident

7. Date on which you first visited a doctor with complaints related to this illness/injury. d d m m y y y y

8. Name and Address of the attending Medical Practitioner

Dr.
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.

9. Please give details of the treatment you have received including dates of out patient or inpatient treatment

10. Have any of your blood relatives suffered from similar or related illness? ☐ Yes ☐ No

If YES, give details of when it was initially diagnosed

11. Have you been hospitalized? ☐ Yes ☐ No

If Yes, Name & Address of Hospital/Nursing Home

Plot No./Door No. Building Name

Road/Street/Sector

Area

Taluka/Village/District/City Pin Code

State Country

Telephone Mobile

E-mail Fax

12. Date of admission d d m m y y y y Date of discharge d d m m y y y y

13. Is this the first claim under this Policy? ☐ Yes ☐ No

If NO, please quote previous claim number and details

14. Total amount claimed (Rs)

In support of the above claim, I enclose the following original documents (Please indicate)

- Duly completed Claim Form
- Certificate from treating Medical Specialist confirming the diagnosis of the named illness or performance of surgery.
- Details of first symptoms and date of occurrence of the disease/illness/injury/surgery along with complete medical history of the Insured/Insured Person.
- Confirmation that the Insured Event does not relate to
  - i) any pre-existing illness
  - ii) any disease/illness/injury which existed within the first 3 months of commencement of period of Insurance.
- In case of Hospitalisation, please provide hospital discharge card/clinical notes etc.
- FIR copy or medico legal certificate (for Illness resulting from Accident).
- Any other relevant 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. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.

I also consent & authorize the Company to seek medical information from any Hospital/Medical Practitioner who has at any time attended on me.

I hereby authorise any hospital, physician, or other person who has treated attended or examined me, to furnish to the Company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment of Insured/ Insured Person including copies of relevant hospital or medical records. A Photostat copy of this authorization shall be considered as effective and valid as the original.

Dated at _____ this _____ day of _____20___

Signature of the Claimant