

**Reliance Individual Mediclaim Policy  
Claim Form**

Issuance of this form does not imply acceptance of the liability

(To be filled in BLOCK LETTERS)

**Please answer all questions fully. Please attach all bills, receipts and credit card slips pertaining to your claim.**

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

2. Policy No. \_\_\_\_\_  
Period of Insurance | d | d | m | m | y | y | y | y | to | d | d | m | m | y | y | y | y |  
Sum Insured \_\_\_\_\_

3. 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 \_\_\_\_\_

4. Name of the Insured Person (in respect of whom the claim is made)  
\_\_\_\_\_  
Relationship with the Insured \_\_\_\_\_  
Present completed age \_\_\_\_\_  
Occupation \_\_\_\_\_

5. Date of injury sustained or disease/illness first detected | d | d | m | m | y | y | y | y |  
6. Please describe the injury sustained or disease/illness contracted (including cause)  
\_\_\_\_\_

7. Name of the attending Medical Practitioner  
Dr. \_\_\_\_\_  
Address of the attending Medical Practitioner  
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. \_\_\_\_\_

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8. Name of the Hospital/Nursing Home

\_\_\_\_\_

Address of the Hospital/Nursing Home

Plot No./Door No. \_\_\_\_\_ Building Name \_\_\_\_\_

Road/Street/Sector \_\_\_\_\_

Area \_\_\_\_\_

Taluka/Village/District/City \_\_\_\_\_ Pin Code \_\_\_\_\_

State \_\_\_\_\_ Country \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail \_\_\_\_\_

9. Date of admission [ d | d | m | m | y | y | y | y ] 10. Date of discharge [ d | d | m | m | y | y | y | y ]

11. Date and mode of intimation given to the TPA [ d | d | m | m | y | y | y | y ] [ m | o | d | e ]

If TPA not intimated, please provide reasons for the same \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. If the claim is for Domiciliary Hospitalisation, please indicate

Date of commencement of treatment [ d | d | m | m | y | y | y | y ]

Date of completion of treatment [ d | d | m | m | y | y | y | y ]

Name of attending Medical Practitioner. Is it same as mentioned under point 7.  Yes  No

Dr. \_\_\_\_\_

If No, address of attending Medical Practitioner

Plot No./Door No. \_\_\_\_\_ Building Name \_\_\_\_\_

Road/Street/Sector \_\_\_\_\_

Area \_\_\_\_\_

Taluka/Village/District/City \_\_\_\_\_ Pin Code \_\_\_\_\_

State \_\_\_\_\_ Country \_\_\_\_\_

Telephone No. \_\_\_\_\_ Fax \_\_\_\_\_

Registration No. \_\_\_\_\_

13. Have the Police Authorities been informed?  Yes  No  
(For accident case only)

14. Are you at present covered under any other similar type of schemes like Personal Accident, Cancer Insurance, Mediclaim (Individual or Group), Health Insurance, etc? If Yes, please give particulars of the Policy Type/Policy No./Insurance Company

\_\_\_\_\_  
\_\_\_\_\_

Is this the first year of coverage under any Health Insurance Policy?  Yes  No

If NO, since when have you been continuously Insured under any Health Insurance Policy. Please provide the necessary details (Policy No., etc.)? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

15. Schedule of expenses incurred under the following benefits (to be supported by original bills/receipts, cash memos etc.) Please refer your Policy for coverage details. In case of insufficient space, please attach an additional sheet.

- a. Hospitalisation \_\_\_\_\_
- b. Day Care Treatment \_\_\_\_\_
- c. Pre Hospitalisation \_\_\_\_\_
- d. Post Hospitalisation \_\_\_\_\_
- e. Ambulance Charges \_\_\_\_\_
- f. Domiciliary Hospitalisation \_\_\_\_\_
- g. Health checkup Expenses \_\_\_\_\_

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 of information, my right to claim reimbursement of the said expenses shall be absolutely forfeited.

I also consent & authorise the THIRD PARTY ADMINISTRATOR to seek medical information from any Hospital/Nursing Home/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/Nursing Home on my behalf for full and final settlement of Hospital/Nursing Home bills.

I hereby authorise any Hospital/Nursing Home, Physician, or other person who has treated attended or examined me, to furnish to the Company, or its authorised representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment including copies of relevant hospital or medical records, a photostat copy of this authorisation shall be considered as effective and valid as the original.

\_\_\_\_\_  
Signature of the Insured/Insured Person

Date: \_\_\_\_\_

Place: \_\_\_\_\_

#### Document check list for health:

Documents to be attached while claiming under the following sections:

##### Hospitalisation/Day Care Treatment

1. First prescription of doctor with commencement date of the symptom of disease.
2. Treatment papers along with doctors prescriptions.
3. Investigation reports (X-ray/Scan/ECG, Laboratory etc).
4. Original medical bills and receipt of hospital, doctors, medical shops, diagnostic centre etc supported by doctor's advice.
5. Hospital discharge card.
6. Copy of FIR (in case of accident).

##### Domiciliary Hospitalisation

1. First prescription of doctor with commencement date of the symptom of disease.
2. Treatment papers along with doctors prescriptions.
3. Investigation reports (X-ray/Scan/ECG, Laboratory etc).
4. Original medical bills and receipt of doctors, medical shops, diagnostic centre etc supported by doctor's advice.
5. Copy of FIR (in case of accident).
6. Certificate from attending doctor/physician stating the condition of the patient is not permissible for him/her to be removed to hospital/nursing home or documentary proof of lack of accommodation in hospital/nursing home

## Attending Medical Practitioner's Statement

To be answered by attending Medical Practitioner in complete.  
(To be filled in case discharge summary does not contain the following information)

1. Name of the Insured (in respect of whom the treatment is given)  
\_\_\_\_\_
2. Age \_\_\_\_\_
3. 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 \_\_\_\_\_
4. Nature of the disease suffered by Insured  
\_\_\_\_\_
5. What treatment was given/operations performed, if any?  
\_\_\_\_\_
6. When did the first symptom appear? | d | d | m | m | y | y | y | y |  
\_\_\_\_\_
7. Whether the present ailment is pre-existing or caused by any pre-existing ailment? If Yes, please specify  
\_\_\_\_\_

### For accident case:

8. Are the injuries traceable to any pre-existing ailment/infirmities?  
\_\_\_\_\_
9. Was he/she under the influence of intoxicants or drugs at the time of accident?  
\_\_\_\_\_
10. Any medico legal case filed?  
\_\_\_\_\_
11. Have you provided medical treatment to the Insured previous to this treatment? If YES, specify time since when you have been attending him/her?  
\_\_\_\_\_
12. If you have treated him/her for any previous illness or injury, please give details  
\_\_\_\_\_  
\_\_\_\_\_

Signature of the Medical Practitioner

Date: \_\_\_\_\_

Name Dr. \_\_\_\_\_

Regn. No. \_\_\_\_\_

Address of the Doctor

Plot No./Door No. \_\_\_\_\_ Building Name \_\_\_\_\_

Road/Street/Sector \_\_\_\_\_

Area \_\_\_\_\_

Taluka/Village/District/City \_\_\_\_\_ Pin Code \_\_\_\_\_

State \_\_\_\_\_ Country \_\_\_\_\_

Telephone \_\_\_\_\_ Mobile \_\_\_\_\_

E-mail \_\_\_\_\_ Fax \_\_\_\_\_