# UNITED INDIA INSURANCE CO., LTD.,

(Subsidiary of General Insurance Company of India)

**Regd. & Head Office : 24, Whites Road, Chennai - 600 014.**

## REVISED MEDICLAIM INSURANCE POLICY

(Individual)

## CLAIM FORM

Claim No. Date :

Issuance 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.

FOR OFFICE USE ONLY

1. Name of the Insured : (in whose name policy is issued) SURNAME INITIALS
2. Details of the Insured person (in respect of whose claim is made) :
   - (a) Name & Relationship to the insured :
   - (b) Present Completed Age :
   - (c) Occupation :
   - (d) Residential Address : .....
   - (e) Telephone No. Residence :
     Office :
     Cell :
3. Policy No. :
4. Nature of Disease / Illness contracted or injury suffered :
5. Date of injury sustained or Disease/illness first declared : Date Month Year
6. (a) Name and Address of the attending Medical Practitioner: .....
   Pincode.....
   State / U. Territory.....
   - (b) Qualification & Telephone No. :
   - (c) Registration No. :
7. (a) Name and Address of the Hospital/Nursing Home/Clinic: .....
   Pincode.....
   State / U. Territory.....
   - (b) Date of Admission : Date Month Year
   - (c) Date of Discharge : Date Month Year
8. If the claim is forDomiciliary Hospitalisation, please indicate
   - (a) Date of Commencement of treatment : Date Month Year
   - (b) Date of completion of treatment : Date Month Year
   - (c) Name & Address of attending Medical Practitioner : .....
     Pincode.....
     State / U. Territory.....
   - (d) Telephone No. :
   - (c) Registration No. :

I have incurred on the treatment of Disease / illness / Accident referred to above the expenses as per the details given be me in the Schedule of Expenses given overleaf.

I support of the above claim, I enclose following documents (please indicate by)

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 Pathological test reports from a pathologist supported by the note from the attending Medical Practitioner / Surgeon demanding such Pathological test.

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

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

6. In case of Domicillary Hospitalisation, Receipt from qualified nurse who attended the patient at his / her residence duly supported by a certificate from attending Medical Practitioner.

7. Certificate from the attending Medical Practitioner giving reasons for treatment under domicillary Hospitalisation Clause of policy.

8. Certificate from the attending Medical Practitioner / Surgeon that the patient is fully cured.

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 of Insurance.

Dated at ..... this ..... day of.....200

(Signature of the Claimant)

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FOR OFFICE USE

Date of Claim ☐☐☐☐☐

POLICY NUMBER ..... SUM INSURED OPTED .....

ADD CUMULATIVE BONUS ALLOWED..... CLAIM NO. ☐ / ☐☐ / ☐☐ / ☐☐ / ☐☐☐☐☐ / ☐☐

| SHEDULE OF EXPENSES INCURRED BY THE CLAIMANT | | | | |
|---|---|---|---|---|
| Details of Expenses claimed under Hospitalisation / Domicillary Hospitalisation (To be supported by Bills / Receipts, Cash Memos etc....) | Amount Claimed (1) | Amount not Payable (2) | (1) - (2) (3) | Amount Payable (4) |
| I (A) HOSPITALISATION BENEFITS : | | | | |
| (a) Room, Board, Nursing Expenses for .....days @ Rs..... per day | | | ☐☐☐☐☐ | |
| (b) I.C. Unit for .....days @ Rs..... per day | | | ☐☐☐☐☐ | |
| I. (B) HOSPITALISATION BENEFITS : OTHER THAN ABOVE (including pre. & post hospitalisation) | | | | |
| (1) Surgeon, Anaesthetist, Medical Practitioner Consultants, Specialists fees. | | | ☐☐☐☐☐ | |
| (2) Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials, X-Ray, Dialysis, Chemotheraphy, Radiotherapy, cost of Pacemaker, artificial limbs & cost of organs and similar other expenses. | | | ☐☐☐☐☐ | |
| TOTAL | | | | |
| II. DOMICILLARY HOSPITALISATION BENEFITS : (Non-surgical treatment) | | | | |
| (1) Medical Practitioner, Consultants, Specialists fees for visits etc., | | | ☐☐☐☐☐ | |
| (2) Blood, Oxygen, Diagnostic Materials & X-Ray, Employment of qualified Nurses, Medicines and Drugs and similar expenses. | | | ☐☐☐☐☐ | |
| TOTAL | | | | |

| SHEDULE OF EXPENSES INCURRED BY THE CLAIMANT | | FOR OFFICE USE ONLY | | |
|---|---|---|---|---|
| Details of Expenses claimed under Hospitalisation / Domicillary Hospitalisation (To be supported by Bills / Receipts, Cash Memos etc.,) | Amount Claimed (1) | Amount not Payable (2) | (1) - (2) (3) | Amount Payable (4) |
| III. MATERNITY EXPENSES BENEFIT EXTENSION : | | | | |
| (a) Room, Board, Nursing Expenses for days @ ..... per day | | | | |
| (b) Gynaecologist / Obstertrician / Surgeon / Physician Anaesthetist fees.. | | | | |
| Normal delivery, Miscarriage and Abortion, Caesarian Section / Abdominal Opening for extra uterine pregnancy. | | | | |
| (c) Diagnostic Materials, X-Ray, Medicines and Drugs, Injections etc.... | | | | |
| TOTAL | | | | |

SIGNATURE OF THE CLAIMANT :

DATE :

PLACE :

Less : Amount paid since inception of the policy

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Net Payable

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Prepared by :

Checked by :

Approved by :

Passed for payment of Rs.....

Total amount payable under the claim

Less : part payment if any

Net amount payable

Rs..... in case entire claim is

Rs..... not admissible, reasons

Rs..... thereof