



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.

Name of the Insured :

(in whose name policy is issued)

SURNAME

INITIALS

FOR OFFICE USE ONLY

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 :

Policy No. :

Nature of Disease / Illness contracted or injury suffered :

Date of injury sustained or Disease/illness first declared :

Date

Month

Year

(a) Name and Address of the attending Medical Practitioner:

.....

Pincode.....

State / U. Territory.....

(b) Qualification & Telephone No. :

(c) Registration No. :

(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

If the claim is for Domiciliary 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)

FOR OFFICE USE

Date of Claim

ADD CUMULATIVE BONUS ALLOWED.....

CLAIM NO. / / / / /

SCHEDULE 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 fordays @ Rs..... per day			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
(b) I.C. Unit fordays @ Rs..... per day			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
I. (B) HOSPITALISATION BENEFITS : OTHER THAN ABOVE (including pre. & post hospitalisation)				
(1) Surgeon, Anaesthetist, Medical Practitioner Consultants, Specialists fees.			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
(2) Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials, X-Ray, Dialysis, Chemotherapy, Radiotherapy, cost of Pacemaker, artificial limbs & cost of organs and similar other expenses.			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
TOTAL				
II. DOMICILLARY HOSPITALISATION BENEFITS :				
(Non-surgical treatment)			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
(1) Medical Practitioner, Consultants, Specialists fees for visits etc.,			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
(2) Blood, Oxygen, Diagnostic Materials & X-Ray, Employment of qualified Nurses, Medicines and Drugs and similar expenses.			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
TOTAL				

SCHEDULE 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	<input type="text"/>		<input type="text"/>	
(b)	Gynaecologist / Obstetrician / Surgeon / Physician Anaesthetist fees.. Normal delivery, Miscarriage and Abortion, Caesarian Section / Abdominal Opening for extra uterine pregnancy.	<input type="text"/>		<input type="text"/>	
(c)	Diagnostic Materials, X-Ray, Medicines and Drugs, Injections etc...,	<input type="text"/>		<input type="text"/>	
TOTAL					

SIGNATURE OF THE CLAIMANT :

Less : Amount paid since inception of the policy

DATE :

.....
Net Payable

PLACE :

FOR OFFICE USE ONLY

Prepared by :

Total amount payable under the claim

Rs..... in case entire claim is

Checked by :

Less : part payment if any

Rs..... not admissible, reasons

Approved by :

Passed for payment of Rs.....

Net amount payable

Rs..... thereof