HIMALAYAN **E**verest **I**NSURANCE **Co. L**td.
Babarmahal, GPO Box No. 148, Kathmandu, Nepal.
Tel. 4231790, 4231581

GROUP HOSPITAL INDEMNITY CLAIM FORM (HIP)

1. Name of the Office/Insured: **Policy No.:**

a) Employee's Name: Age/Sex:

b) Occupation: Address/Contact No.:

c) Name/Age/Sex of the patient:

d) Employee's relation to the patient:

2. Hospitalization was due to:-

a) Illness (Date of symptoms started) Date 1st. treated:

b) Accident (Date/ time of accident) Date Treated:

3. Describe in detail diagnosis or symptoms of illness or nature of injuries and how injuries were caused:-

a) Date admitted: Date discharged: Name of Hospital:

b) Name of Doctor/s in attendance:

c) Any follow-up visit/s required:

4. Was any doctor consulted for the above illness/injury at any time before hospitalization? If so, give details:

Name	Address	Date/s

5. Details of your regular doctor or any other doctor or hospital consulted for any other complaints, disorders or illness for the past three years?

Name	Address	Date	Reason for visit

6. Are you claiming from any other insurance company or other sources in respect of this hospitalization? If yes, please provide the following information;

Name of Company	Amount claimed	Policy Number

7. Was the claimant outside Nepal for more than 90 consecutive days? If yes, please give details of his/her visit and period of stay:

I/We hereby declare that the foregoing statements are true to the best of my/our knowledge.

Signature of Policy holder with official seal/stamp Signature of Claimant

Date: Date: