

Reliance Travel Care Insurance Policy Claim Form A

	Medical Expenses/Dental Ca	re Expenses
1.	In case of disease/illness	
	Please provide the details of the	he disease/illness
	Please provide the cause of the	ne disease/illness
	Date of onset of disease/illness	[d,d m,m y,y,y,y]
2.	In case of accident	
	Please provide the details of the	he accident
	Please provide the cause of the	ne accident
	Date of accident	[d,d m,m y,y,y]
	Place of the accident	
3.	Please specify whether the Pa	atient/Insured person was hospitalized for treatment of disease/illness/injury:
	If yes, period of Hospitalization Treatment done for disease/illi	
4.	Nature of Treatment done for	disease/illness/injury
5.	Name of Hospital/Nursing Hor	ne where treatment of the disease/illness/injury was given:
6.	Address Flat/Building/Door/Block No.	
	Road/Street/Sector	
	Area	
	Taluka/Village/District/City	Pin Code Pin Code
	State	Country Country
	Telephone No.	Fax L
7.	Name of the Attending Doctor/F	Physician Dr
8.	Address	
	Flat/Building/Door/Block No.	
	Road/Street/Sector	
	Area	
	Taluka/Village/District/City	Pin Code
	State	Country
	Telephone No.	Mobile
	Email	Fax

In case of a claim under any of the add-on benefits, please fill in the following details (Applicable only if the Insured Person has opted for the additional add-on benefits under the Student Plan)

Sr. No.	Coverage						Total Expense	es
1.	Treatment of Mental and N	lervous Disorders incl	uding Alcohol	and Drug Dep	endency			
2.	Impatient Hospitalization e	expenses related to Pro	egnancy/Child	l birth.				
3.	Medical Expenses for Inter	r collegiate sports inju	ries.					
4.	Cancer Screening and Mai	mmographic Examina	tions.					
5.	Child Care Benefits							
6.	Chiropractic Treatment							
7.	Physiotherapy Treatment							
8.	Skilled Nursing Treatment							
	Vas the disease/illness/injury of yes,	caused and/or aggrav	ated by any p	re-existing con	dition/disease/illne	ess/injury?		∕es ☐ No
b. H	las the Patient/insured person eceived	on been treated for the	ne disease/illr	ness/injury? Pl	ease specify the	necessary	details of the	treatment
c. N	lame of the Consulted Physicia	an: Dr. L						
d. A	address of the Consulted Physi	ician						
F	lat/Building/Door/Block No.							
F	Road/Street/Sector							
A	Area							
Т	aluka/Village/District/City			Р	in Code L			
S	State			с	ountry			
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	Repatriation of Remains/Em	ergency Evacuation												
9.	Date of Departure	[d	10. I	Date of Arriva	al [d d d	m m y	у гу гу							
11.	Flight No.		From			_ To								
12.	In case of a claim for emerg	ency evacuation:												
	Cause of disease/illness/injury leading to evacuation:													
	Date of injury or commencement	ent of disease/illness:	m y y	јују РІ	ace									
13.	In case of a claim for repatri	ation of remains/funeral expenses:												
	Cause of Death													
	Date of Death		Place of	Death										
14.	Please provide the details of the	he expenses related to the repatriation	n/funeral/e	evacuation										
	Detail of Expe	enses incurred		Date	PI	ace	Amount							
				1										
			<u> </u>	1										
						Total Due								
Atter	nding Physician's Statement (To be filled up by the Attending Do	ctor/Phys	sician)										
15.	Please provide the following d	letails of the Patient/Insured Person												
	Name Mr. Mrs.													
	Age	yrs		Sex	М 🗆 F									
	Address						1							
	Flat/Building/Door/Block No.													
	Road/Street/Sector													
	Area			Din Code										
	Taluka/Village/District/City State													
	Fax													
	Phone No.			Liliali Iu. L										
16.		when the Patient/Insured Person first co		/OU										
10.	ricase specify the date a time (when the ration who are a resolution of	oritacioù y											
17.	Please provide the details of the	e diagnosis and treatment given for the	disease/il	Iness/injury_										
18.	Please provide the details of mo	edical investigation done, if any												
19.	In case of accidental injury													
	Does the cause of accident as s	stated by the Patient/Insured Person ta	lly with the	injuries notic	ed by you?_									
	Was the Patient/Insured Perso aggravate his/her condition:	on suffering from any condition/disease	e/illness/inj	iury which ma	y have conti	ibuted to the	accident or likely to							
	If yes, please specify the neces	ssary details												
		n under the influence of alcohol or intox					Yes No							
	it yes, please specify the neces	ssary details												

If yes, please give the necessary details: Is the condition due to pregnancy? Was the Patient/Insured Person hospitalized for the treatment of the disease/illness/injury? If yes, please provide the following details Period of Hospitalization: From d d d m m y y y y y to d d d m m y y y y y y Name of Hospital/ Nursing Home where treatment of the disease/illness/injury was given: Address Flat/Building/Door/Block No. Road/Street/Sector Area Taluka/Village/District/City Pin Code Fax Name of the attending Doctor/Physician Dr.	Was the disease/illness source	d and/or aggravated due to any pro-existing condition/discase/illness/injury?	Yes
Was the Patient/Insured Person hospitalized for the treatment of the disease/illness/injury? If yes, please provide the following details Period of Hospitalization: From dddmmmy,yyyy to dddmmyyyyyyy Name of Hospital/ Nursing Home where treatment of the disease/illness/injury was given: Address Flat/Building/Door/Block No. Road/Street/Sector Area Taluka/Village/District/City Pin Code Country Address Flat/Building/Door/Block No. Road/Street/Sector Area Address Flat/Building/Door/Block No. Road/Street/Sector Area Taluka/Village/District/City Pin Code Country Pin Code Country Address Flat/Building/Door/Block No. Road/Street/Sector Area Taluka/Village/District/City Pin Code Country Mob. No. Mob. No.			res
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Address Flat/Building/Door/Block No. Road/Street/Sector Area Taluka/Village/District/City State Telephone No. Mob. No.	Fax		
Flat/Building/Door/Block No.	Name of the attending Doctor	/Physician Dr	
Road/Street/Sector	Address Flat/Building/Door/Block No.		1 1
Area	-		
Taluka/Village/District/City			
State			
Telephone No.			
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Date: dddm,my,y,y,y	Attending Doctor's/Physician	n's Signature Place:	
	Compassionate Visit		
Attending Doctor's/Physician's Signature Place:	Please specify the details of d	lisease/illness/injury:	
Attending Doctor's/Physician's Signature Place:			
Attending Doctor's/Physician's Signature Place: Compassionate Visit	Detection is a side of the sector of silver		
Attending Doctor's/Physician's Signature Compassionate Visit Please specify the details of disease/illness/injury:		_	7 V
Attending Doctor's/Physician's Signature Compassionate Visit Please specify the details of disease/illness/injury: Date of accident/onset of ailment:			_ Yes L_
Attending Doctor's/Physician's Signature Compassionate Visit Please specify the details of disease/illness/injury: Date of accident/onset of ailment: Was the Patient/Insured Person hospitalized?	Period of Hospitalization: F	-rom	

20. In case of disease/illness

26.	Please provide the following details of the Hospital/Nursing Home where the treatment for disease/illness/injury was taken:																												
	Name of the Hospital/ Nursing	g Home																											
	Address Flat/Building/Door/Block No.		1		1		1		- 1	ı												Ш.							
	Road/Street/Sector												_																
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	Telephone No.													Mol	b. N	o.	L												
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27.	Was the disease/illness/injury caused due to or aggravated by any pre-existing condition/disease/illness/injury: ☐ Yes ☐ No													No															
	If yes, please specify the necessity	essary de	etails	s																									
28. 29.																													
30. Please fill in the following details, only in case the Patient/Insured Person has opted for the Reliance Travel Care Policy-Student Plan										re I	nsu	ıran	ice																
	Please specify as to who has	been hos	spita	alize	d:		Pat	ient/	Insu	ıred	Pe	rsoı	n] In	nm	edi	ate	far	nily	me	emt	oer (of th	he Ir	าธนเ	ed i	Pers	son
	Name of the family member h	ospitaliza	atior	า:																									
	Relationship with the Patient/I	Insured F	ers	on: _																									