UNITED INDIA INSURANCE CO. LTD.,
(A subsidiary of General Insurance Corporation of India)
Regd. & Head Office: United India House, 24, Whites Road, Chennai 600 014.

MEDICLAIM INSURANCE POLICY CLAIM FORM

Issuance of this form does not amount to admis sion 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.

1	Name of the Insured (in whose name policy is issued)		:			
2	Details of the Insured person (in respect of whom claim is made)		:			
	(a)	Name & relationship to the Insured	:			
	(b)	Present completed age	:			
	©	Occupation	:			
	(d)	Residential address	:			
3	Policy no.		:			
4	Nature of disease/illness contracted or injury suffered		:			
5	Date of injury sustained or Diseases/illness first detected		:	Date	Month	Year
6	(a)	Name & address of the attending Medical Practitioner	:			
	(b)	Registration no.	:			
	©	Qualification & Tel. no.	:			
7	(a)	Name & address of the Hospital/Nursing Home	:			
	(b)	Registration no.	:			
	©	Date of Admission	:	Date	Month	Year
	(d)	Date of Discharge	:	Date	Month	Year
8	If the claim is for Domiciliary Hospitalizations, please indicate					
	(a)	Date of commencement of treatment	:	Date	Month	Year
	(b)	Date of completion of treatment	:	Date	Month	Year
	©	Name & Address of attending Medical Practitioner	:			

	(d)	Telephone no.	:	
	(e)	Registration no.	:	

I have incurred on the treatment of Disease/illness/accident referred of above, the expenses as per the _____ given by me in the Schedule of Expenses given overleaf.

I hereby warrant the truth of foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statements, 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 or Insurance.

Dated at _____ this _____ day of _____ 20

Signature of the Claimant

SCHEDULE OF EXPENSES INCURRED AND BEING CLAIMED BY THE CLAIMANT

Sr. No.	Receipt		Nature of Expenditure	Amt. claimed (`)	Amt. payable (`)
	No.	Date			

- **Discharge Card incorporating detailed Discharge Summary and Case History is mandatory to be submitted separately with the Claim Form.**

Signature of the Insured Person

W.E.F. 16/08/2011, all Health claims will be paid through ELECTRONIC TRANSFER (NEFT/RTGS), hence it is mandatory to give following details to TPA :

1	Name of the Account holder	:	
2	Bank name	:	
3	Full Bank Account no. (without /,- or any special characters)	:	
4	IFSC code	:	
5	Account type (savings/current)	:	
6	Bank address	:	
7	Mobile number	:	
8	E-mail ID	:	

Attach copy of cancelled cheque leaf to ensure accuracy of details provided.

Note: Payment of claim will be made through electronic transfer only. Cancelled cheque leaf of the bank account to which the claim amount need to be transferred need to be mandatorily submitted along with documents.