



GENERAL  
INSURANCE

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CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A

TO BE FILLED IN BY THE INSURED

(To be filled in BLOCK LETTERS)

The issue of this Form is not to be taken as an admission of liability

SECTION A - DETAILS OF PRIMARY INSURED

- a) Type of claim  
☐ Hospitalization ☐ Pre Hospitalization ☐ Post Hospitalization ☐ Health check-up ☐ OPD
- b) Pre authorization obtained ☐ Yes ☐ No
- c) Policy type ☐ Individual ☐ Group
- d) Group/Company name \_\_\_\_\_
- e) Policy No **524681369** f) Sl. No/Certificate No \_\_\_\_\_
- g) Company/TPA ID No. \_\_\_\_\_ h) Name **Deepa**
- i) Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Pincode \_\_\_\_\_  
Phone No **8136987452** Email ID. **deepa@gmail.com**
- j) PAN No \_\_\_\_\_
- k) Monthly Income: ☐ Up to ₹ 20,000 ☐ ₹ 20,001 to ₹ 50,000 ☐ ₹ 50,001 to ₹ 1,00,000 ☐ ₹ 1,00,001 and above

SECTION B - DETAILS OF INSURANCE HISTORY

- a) Currently covered by any other Mediciam/Health Insurance ☐ Yes ☐ No
- b) Date of commencement of first insurance without break | d | d | m | m | y | y | y | y |  
\_\_\_\_\_
- c) If yes, company name \_\_\_\_\_  
Policy No \_\_\_\_\_ Sum Insured ₹ \_\_\_\_\_
- d) Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No  
Date | d | d | m | m | Diagnosis \_\_\_\_\_
- e) Previously covered by any other Mediciam/Health Insurance ☐ Yes ☐ No
- f) If yes Company Name \_\_\_\_\_

SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED

- a) Name \_\_\_\_\_
- b) Gender ☐ Male ☐ Female c) Age - \_\_\_\_\_ years \_\_\_\_\_ Months d) Date of birth | d | d | m | m | y | y | y | y |  
\_\_\_\_\_
- e) Relationship to Primary insured: ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother Other - Please Specify \_\_\_\_\_
- f) Occupation: ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired Other - Please Specify \_\_\_\_\_
- g) Address (if different from above) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Pin Code \_\_\_\_\_  
Phone No \_\_\_\_\_ Email Id \_\_\_\_\_

An ISO 9001:2015 Certified Company

Reliance General Insurance Company Limited. IRDAI Registration No. 103. Registered & Corporate Office: Reliance Centre, South Wing, 4th Floor, Santacruz (East), Off. Western Express Highway, Mumbai 400055. Corporate Identity No.U66603MH2000PLC128300. Trade Logo displayed above belongs to Anil Dhirubhai Ambani Ventures Private Limited and used by Reliance General Insurance Company Limited under License. RGI/MCOM/CO/CLAIM-/Ver.1.2/050820.

## SECTION D - DETAILS OF HOSPITALIZATION

- a) Name of Hospital where admitted \_\_\_\_\_
- b) Room Category occupied ☐ Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room
- c) Hospitalization due to ☐ Injury ☐ Illness ☐ Maternity
- d) Date of Injury/Date disease first detected /Date of delivery | d | d | m | m | y | y | y | y |
- e) Date of Admission | d | d | m | m | y | y | y | y | f) Time | H | H | M | M |
- g) Date of discharge | d | d | m | m | y | y | y | y | h) Time | H | H | M | M |
- I) If injury give cause: ☐ Self inflicted ☐ Road traffic accident ☐ Substance abuse /Alcohol consumption
- I) If Medico legal ☐ Yes ☐ No ii) Reported to police ☐ Yes ☐ No
- iii) MLC report & Police FIR attached ☐ Yes ☐ No j) System of medicine \_\_\_\_\_

## SECTION E - DETAILS OF CLAIM

- a) Details of treatment expenses claimed
- i. Pre hospitalization expenses ₹ \_\_\_\_\_ ii. hospitalization expenses ₹ \_\_\_\_\_
- iii. Post hospitalization expenses ₹ \_\_\_\_\_ iv. Health check up cost ₹ \_\_\_\_\_
- v. Ambulance charges ₹ \_\_\_\_\_ vi. Others(code) ₹ \_\_\_\_\_
- TOTAL ₹ \_\_\_\_\_
- vii. Pre hospitalization period \_\_\_\_\_ days viii. Post hospitalization period \_\_\_\_\_ days
- b) Claim for Domiciliary Hospitalization ☐ Yes ☐ No (if yes provide details in annexure)
- c) Details of Lump sum/cash benefit claimed i. Hospital Daily Cash ₹ \_\_\_\_\_/- ii Surgical cash ₹ \_\_\_\_\_/-
- iii Critical illness benefit- ₹ \_\_\_\_\_/ iv Convalescence ₹ \_\_\_\_\_/-
- v. Pre/Post hospitalization Lump sum benefit ₹ \_\_\_\_\_/- vi Others ₹ \_\_\_\_\_/-
- TOTAL ₹ \_\_\_\_\_/-

## SECTION F - DETAILS OF BILLS ENCLOSED

S.No	Bill No	Date	Issued By	Towards	Amount ₹)
1		d   d   m   m   y   y   y   y		Hospital main Bill	
2		d   d   m   m   y   y   y   y		Pre hospitalization Bills _____ Nos	
3		d   d   m   m   y   y   y   y		Post hospitalization Bills _____ Nos	
4		d   d   m   m   y   y   y   y		Pharmacy Bills	
5		d   d   m   m   y   y   y   y		Other expenses if any _____	
6		d   d   m   m   y   y   y   y			
7		d   d   m   m   y   y   y   y			
8		d   d   m   m   y   y   y   y			
9		d   d   m   m   y   y   y   y			
10		d   d   m   m   y   y   y   y			

## CLAIM DOCUMENTS SUBMITTED CHECK LIST

S.No	Documents	
1	<input type="checkbox"/> Claim form duly signed	7 <input type="checkbox"/> Pharmacy bill
2	<input type="checkbox"/> Copy of the claim intimation, if any	8 <input type="checkbox"/> Operation theatre notes
3	<input type="checkbox"/> Hospital main bill	9 <input type="checkbox"/> ECG
4	<input type="checkbox"/> Hospital break up bill	10 <input type="checkbox"/> Doctor's request for investigation
5	<input type="checkbox"/> Hospital bill payment receipt	11 <input type="checkbox"/> Investigation reports (including CT/MRI/USG/HPE)
6	<input type="checkbox"/> Hospital discharge summary	12 <input type="checkbox"/> Doctor's prescriptions
		13 <input type="checkbox"/> Others

As per policy terms & conditions, the Company reserves its right to have the Insured examined by a Doctor appointed by it for verification of diagnosis.

## SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

2. Bank Account No.:
3. Account: ☐ Saving ☐ Current ☐ Other
4. Name of the Bank
5. Branch
6. MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)
7. IFSC Code (11 character code appearing on your cheque leaf)

☐ I understand that any refund due on the premium payment / any payment / claims to be directly credited to my aforesaid Bank Account.\*

\*As per IRDAI, its mandatory that all payments made to the insured are only through electronic mode.

## SECTION H - DECLARATION BY THE INSURED

I hereby declare that the information furnished in this claim form is true and correct to the best of my knowledge and belief. If I made any false or untrue statement, suppression or concealment of any material fact with respects to questions asked in relation to the claimed, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA/Insurance Company, to seek necessary medical information /documents from any hospital/Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills /receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post hospitalization claim, if any.

Date 

d	d	m	m	y	y	y	y
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 Place \_\_\_\_\_ Signature of the Insured \_\_\_\_\_

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