RASTRIYA BEEMA COMPANY LIMITED

RBCL Building, Ramshahpath, Kathmandu, Nepal

MEDICAL AID CLAIM FORM FOR

CONTRIBUTORS OF EMPLOYEE PROVIDENT FUND

Claim No		Policy No.	

This form is issued without admission of liability and should be completed and returned to Rastriya Beema Company Limited, Kathmandu as soon as possible and in any event within 35 days of the discharge from the hospital or 60 days of the commencement of the illness or the date of the accident.

1. Contributor

Name	.....	**Age/Sex**	.....
Permanent Address	.....	**Name and Address of Office**	

2. If injured in an accident	
Date and time of accident	
Where did it occur	
Details of the cause	
Injuries Sustained	

3. Illness

Details of illness

Date of incapacity or diagnosis

4. Medical Attendants Name and address of Doctor Attending Member	
Name & address of all Surgeons, Anesthetists Specialists, Pathologists attending member	

5. Details of Claim

Please fill up the items under which the benefits are claimed in respect of the above illness/accident giving amount claimed and enclosing original receipt, bills, prescription and have the certificate completed by the Doctor giving the medical attention in respect of which a claim is made:

Benefit No	Description of treatment received	
A	Surgeon's Anaesthetist Operation Theatre Charge	
B	X-ray/ or Pathology, Electrical etc. Charge	

C	Charges for Beds/Cabin, Hospitalization etc.	
D	Cost of any surgical appliances	
E	Cost of Medicines& drugs	
F	Maternal Delivery and Caesarian charges	

I declare that I had suffered the above described injuries / illness and that to the best of my knowledge and belief the foregoing particulars are in every aspect true. I also declare that there is no other insurance or other source to cover the items claimed.

Name &Signature of Claimant:

Name of the Employer:

Date:

MEDICAL CERTIFICATE TO BE COMPLETED BY MEMBER'S DOCTOR

I certify that Mr/Mrs/Miss ……..……..was ill/injured from…….……..…. .

Full particulars of Injury/illness: ……..

Medical Examiner's Name: ……

Hospital's Name: ……. Admission Date: …….……....

Discharge Date: ……... NMC No.: …….…..

Signature: ……..… Qualification: ……

Stamp:

MEMBERSHIP CERTIFICATION TO BE COMPLETED BY EMPLOYEE PROVIDENT FUND (EPF)

I certify that Mr/Mrs/Miss ……..…… is the regular contributor of Employee Provident Fund since …….……. The other detail of the contributor is as under:

EPF Contributor Number: …… .

Authorized Signature from EPF

Name: ……. Signature: ……

Stamp of EPF