**NATIONAL INSURANCE COMPANY LTD.**
(a subsidiary of General Insurance Corporation of India)
Regd. Office : 3, MIDDLETON STREET, CALCUTTA – 700 071

ISSUING OFFICE

**HOSPITALISATION AND DOMICILIARY HOSPITALISATION BENEFIT POLICY CLAIM FORM**

Claim No. CL ☐ / ☐☐ / ☐☐ / ☐☐ / ☐☐☐☐☐☐

Issuance of this form does not amount to admission 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. If the claim is under Personal Accident Insurance, please complete a Personal Accident Claim Form.

| | For Office use only |
|---|---|
| 1. Name of the Insured<br>(In whose name policy is issued ) (SURNAME) (INITIALS) | |
| 2. Details of the Insured Person : …….<br>(In respect of whom claim is made) : …….<br>(a) Name & relationship to the Insured : ……..<br>(b) Present completed Age : ……..<br>( c) Occupation : ……..<br>(d) Residential Address : ..……<br>……<br>…… | |
| 3. Policy No. : …….. | |
| 4. Details of Previous Mediclaim Policies : …….<br>i) Policy No. and Policy Period : …….<br>ii) Policy No. and Policy Period : …….<br>iii) Policy No. and Policy Period : …….<br>(Note : Essential if cost of Health Check-up is claimed) | |
| 5. Nature of Disease / illness contracted Or injury suffered : ……. | |
| 6. Date of injury sustained or Disease / Illness first defected : Date Month Year | |

| | |
|---|---|
| 7.<br>(a) Name &Address of the attending Medical Practitioner : ……<br>(b) Qualification & Telephone No. : ……<br>(c) Registration No. : …… ……<br>8.<br>(a) Name & Address of the Hospital / Nursing Home / Clinic : ……<br>Pin Code ……<br>State /U. Territory ……..<br>(b) Date of Admission : ……<br>(c) Date of Discharge : ……<br>9. If the claim is for Domiciliary Hospitalisation, Please indicate : ……..<br>(a) Date of Commencement of treatment :<br>(b) Date of Completion of treatment : ……<br>(c) Name & Address of attending Medical Practitioner : ……<br>(d) Telephone No. : ……<br>(e) Registration No. : …….. | |

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

In support of the above claim , I enclose the following documents (Please indicate by ) :-

1. Bill Receipt and Discharge Certificate / Card from the Hospital.
2. Cash Memos from the Hospital / Chemist(s) , supported by the proper prescription.
3. Receipt and pathological test reports from a pathologist supported by the note from the attending Medical Practitioner / Surgeon demanding such Pathological Tests.
4. Surgeon's certificate Stating nature of operation performed and surgeon's bill and receipt.
5. Attending Doctor's / Consultant's / Speciallist's / Aneasthetist's bill and receipt and certificate regarding diagnosis.
6. In case of domiciliary Hospitalisation , receipt from a qualified nurse who atended the patient at his / her residence duly supported by a certificate from atending Medical Practitioner.
7. Certificate from the attending Medical Practitioner giving reasons for allowing treatment at home.

8. Certificate from the attending Medical Practitioner / Surgeon that the patient is fully cured.

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealments , my right to claim reimbursement of the said expenses shall be absolutely fortified. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.

Dated ……this ……day of ……200

Signature of the Claimant

---

FOR OFFICE USE :

Date of Claim

CLAIM NO. CL

SCHEME A/B

POLICY NO. CATEGORY OF BENEFIT……

| SCHEDULE OF EXPENSES INCURRED BY THE CLAIMANT | TO BE FILLED IN BY THE CLAIMANT | FOR OFFICE USE ONLY | | | |
|---|---|---|---|---|---|
| Details of expenses claimed under Hospitalisation / Domiciliary Hospitalisation (To be supported by Bills / Receipt , Cash Memo etc.) | Amount Claimed (1) | Amount Available (2) | Amount Payable (3) | Amount not payable (1-3) (4) | Balance benefit to the credit (2-3) (5) |

| | | | | | |
|---|---|---|---|---|---|
| I.<br>(A) HOSPITALISATION BENEFITS:<br>(a) Room , Board, Nursing Expenses<br>For ….days……@ …..per day<br><br>(b) I.C.Unit<br>For …..days ……@….per day | | | | | |
| (B) Hospitalisation Benefits other than Room Board & Nursing expenses & ICCU (including Pre & Post Hospitalisation)<br><br>1. Surgeon , Anaesthetist, Medical Practitioner , Consultants , Specialists fees<br><br>2. Anaesthesia , Blood , oxygen , Operation Theatre charges , Surgical Appliances , Medicines & Drugs , Diagnostic, Materials & X-Ray , Dialysis , Chemotherapy , Radiotherapy , cost of Pacemaker artificial limbs & cost of Organs and similar other expenses. | | | | | |
| II.<br>DOMICILIARY HOSPITALISATION :<br><br>1. Medical Practitioners, Consultants & Specialists fees for visits etc.<br><br>2. Blood , Oxygen , Diagnostic materials , X-ray , Employment of qualified Nurses, Medicines and Drugs and similar expenses. | | | | | |
| III.<br>COST OF HEALTH CHECK-UP | | | | | |
| TOTAL RS. | | | | | |

Date :
Place:

Signature of the Claimant

Checked By :

FOR OFFICE USE ONLY

Total amount payable under the cliam Rs……

Less : Advance on account payable, if any Rs. ……

Net amount payable Rs. ……..

Approved By:

In case entire claim is not admissible , reasons thereof

Passed for payment of Rs. ……

COMPETENT AUTHORITY