The New India Assurance Company Limited

Registered & Head Office: New India Assurance Building, 87, M.G. Road, Fort, Mumbai - 400 001.

GROUP MEDICLAIM POLICY (2007)
CLAIM FORM

Claim Number

Issuance of this form does not amount to admission of any liability of under the policy on the part of the Insurers
Please give the following information correctly and completely to enable us process your claim promptly.
All dates to be entered as Date / Month / Year

1. Name of the Insured: SURNAME INITIALS
(in whose name policy is issued)

2. Details of the Insured person :
(in respect of whom claim is made) :
(a) Name & Relationship with the Insured :
(b) Present Completed Age :
(c) Occupation :
(d) Residential Address :

(e) Bank Details
(i) Account No
(ii) Name of the Bank -
(iii) Branch :

3. Policy Number (in Full) :

4. Nature of Disease contracted/Ailment suffered or injury sustained

5. Date on which injury was sustained/Disease Or ailment first detected :

6. (a) Name and Address of the attending Medical Practitioner :
Pin Code
State/ U. Territory
(b) Qualification & Telephone No. :
(c) Registration No. :

(d) Name & Address of the Hospital/Nursing Home / Clinic :_____

_____

_____

Pin Code_____

State / U. Territory_____

PAN of Hospital_____

Registration No._____

(e) Date of Admission :_____

(f) Date of Discharge :_____

6. Are you at present covered under any other similar type of scheme like Personal Accident, Cancer Insurance, Mediclaim (Individual or Group), Health Insurance and the like. If Yes. Please give particulars of each

Sr. No.	Content	Details
	Name of Insurer	
	Insurance Scheme	
	Policy No.	
	Period of cover	
	Claim Amt. Recd./receivable	

(a) Is this the first year of coverage under Mediclaim Policy? Yes / No.

If no, since when have you been continuously insured under Mediclaim Policy. Give details

Year Policy No.	Insurer	Policy No.

(b) (i) Is this the first claim under this policy ? **Yes/No**

(ii) If no, please quote Previous claim details

Year	Policy No.	Insurer	Disease/Ailment/Injury details	Amount claimed and receivable or received

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

1. Bill, Receipt and Discharge certificate / card from the Hospital.
2. Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.
3. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests /pathological
4. Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.
5. Attending Doctor's/ Consultant's/ Specialist's / Anaesthetist's bill and receipt, and certificate regarding diagnosis.
6. Certificate from attending Medical Practitioner / Surgeon that the patient is fully cured.

Summary of expenses incurred for which original bills / receipts / cash memos are enclosed.

Total of Hospital Bill	Rs. _____
Consultant's /Surgeon's /Anesthetist's Fees	Rs. _____
Diagnostics Tests	Rs. _____
Medicines purchased from chemists	Rs. _____
Other expenses not included above (specify)	Rs. _____
Grand Total	Rs. _____

DECLARATION

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 concealment of any fact, 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 availed or claimed under any other Medical Scheme or Insurance.

I ALSO CONSENT AND AUTHORISE THE NEW INDIA ASSURANCE COMPANY LIMITED & THIRD PARTY ADMINISTRATOR TO SEEK MEDICAL INFORMATION FROM ANY HOSPITAL / MEDICAL PRACTITIONER WHO HAS AT ANY TIME ATTENDED ON ME.

I authorize TPA to make payment of the claim admissible as per terms, conditions and limitations of the policy to the **Hospital** on my behalf for full and final settlement of hospital bills.

I also authorize TPA to receive payment from the insurance company as reimbursement of hospital bills incurred on my / the insured person's treatment.

Dated at…(place)…… this……. day of…(month)…….200

Signature of the Claimant