The New India Assurance Company Limited

Head Office: 87, M G Road, Fort, Mumbai-400001

HEALTH PLUS MEDICAL EXPENSES POLICY
CLAIM FORM

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.

I.

II. CLAIM NO. _____.

1. a. Name of the Insured :
   (in whose name policy is issued)
   b. Address of the Insured.

   Phone no. Mobile no. Email Address

2. Details of the insured person
   (In respect of whom claim is made)
   a. Name & relationship to the Insured
   b. Present Completed Age.
   c. Occupation
   d. Residential Address

3. Policy no.
4. Nature of disease/illness contracted or injury suffered.
5. Date on which injury was sustained/Disease or illness first detected.
6. a. Name and address of the attending Medical Practitioner
   b. Qualification & Telephone No.
   c. Registration No.
7. a. Name & address of the Hospital/Nursing Home/Clinic.
   b. Date of Admission.
   c. Date of Discharge.

8. Is this the first year of coverage under
   Health Plus Medical Expenses Policy Yes/No
   If no, since when you have been continuously insured under
   Health Plus Medical Expenses Policy/Mediclaim . Give details.
   Of the first policy availed with effect from.

9. Details of previous claim of the Insured person
   whose claim has been preferred?
   a. Previous claim file reference no. Insurer.
   b. Policy No. Year
   c. Hospitalisation period
   d. Diagnosis.
   e. Whether claim settled/repudiated
   f. Amount of claim if settled.

10. Are you at present
    or in respect of whom
    claim is made is covered under any
    A. other similar type of scheme like P.A., Cancer
    B. Insurance , Mediclaim Policy (Individual/Group),
    C. Health Insurance etc. If so give details.
    a. Name of Insurance Company
    b. Policy no.
    c. Period
    d. Sum Insured

11. Total amount claimed. Rs.
    Summary :
    a) Total of Hospital Bills : Rs.
    b) Consultant's/Surgeon's/Anesthetist's Fees:Rs.
    c) Diagnostic Tests : Rs.
    d) Medicines purchased from Chemists:
    Rs.
    e) Emergency Ambulance Expenses : Rs.
    f) Other expenses not included above :
    Rs.

Grand Total : Rs.

I have incurred medical expenses on the treatment of Disease/Illness/ Accident referred to above.
In support of the above claim, I enclose following original documents (Please indicate by a tick).

1. Bills, receipts and Discharge certificate/card from the Hospital giving case history/Admission discharge dates, summary describing the nature of the complaints and its duration, treatment given, advice on discharge .
2. Hospital Receipts/ bills, Cash Memos from the Chemist(s) duly supported by the proper prescription (printed, numbered, stamped receipts)
3. Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner/Surgeon demanding such Pathological test. All test report for X-Ray, ECG, CT Scan, MRI (Films should not be send unless demanded).
4. Test Reports and prescriptions relating to First/previous consultations for the same or related illness.
5. Surgeon's certificate stating nature of operation performed and Surgeon's bill and receipt.
6. Attending Doctor's Consultant's/ Specialist's/ Anesthetist's bills and receipt and certificate regarding diagnosis.
7. Medical certificate issued by the Treating Doctor on the prescribed format by Insurance Company.
8. FIR (in case of Accidental injury only)

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, 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.

I also consent and authorise the Insurers to seek medical information from any Hospital/Medical Practitioner who has at any time attended on the Insured.

D. Dated at: this Day of 2003.

Signature of the Claimant

Important : Incomplete claim form will cause delay in processing of your claim.

The New India Assce.Co.Ltd., H.O. Mumbai

NEW INDIA ASSURANCE CO. LTD.
MEDICAL CERTIFICATE TO BE FILLED IN BY THE ATTENDING DOCTOR WHO TREATED THE PATIENT.

1. Name of the Patient _____ Age_____
2. Date of Admission _____ Date of Operation_____ Date of Discharge_____

3. Name of the Surgeon/Physician	
4. Diagnosis	
5. Date of first consultation (Prior to Hospitalisation)	
6. (a) With what complaints was the patient admitted for:	
(b) Since when was the patient suffering from the said complaints	
7. Past History of the Patient (if any) with the duration of illness.	
8. Whether the present ailment is a complication of Pre-existing disease.	
9. Whether the disease/disorder is Congenital in nature.	
10. Nature of Surgery/treatment given for the present ailment.	
11. a. Whether Hospital/Nursing Home is registered if yes, Regn.No.	

b. No. of in-patient beds in the Hospital (including ICU)	
d. Whether the hospital is having fully equipped Operation Theatre of its own/qualified nurses round the clock/qualified doctors round the Clock?	

Name and Signature of the Doctor_____
Registration No. _____ Seal _____
Date : _____ Place :