UNITED INDIA INSURANCE CO. LTD.

Regd. & Head Office : 24, Whites Road, Chennai - 600 014

HEALTH INSURANCE POLICY CLAIM FORM

Issuance of this form does not amount to admission 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.

Important: the completed claim form along with supporting documents are to be submitted to the TPA/company within 7 days of completion of treatment or discharge from the hospital.

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

2. Details of the Insured persons (in respect of whom claim is made)
   - a) Name and relationship to the Insured : ....
   - b) Present completed age : ....
   - c) Occupation : ....
   - d) Residential Address : ....
     : ....
     : ....

3. Policy No. : ....

4. Nature of disease/illness : ....

5. Date of injury sustained or disease/ Illness first detected : ....

6. a) Name & Address of the Hospital/ Nursing home/Clinic : ....
   ....
   Pincode : ....
   State/U. Territory ....
   - b) Registration Number of the Hospital/Nursing Home/Clinic
   - c) Date of admission : ....
   - d) Date of discharge : ....

7. **If the claim is for Domiciliary Hospitalisation, Please indicate**
   - a) Date of commencement of treatment : ....
   - b) Date of Completion of treatment : ....
   - c) Name and Address of the Attending Medical Practitioner : ....
     ....
     ....
     Pincode : ....
     State/U.Territory ....
   - d) Telephone No: : ....
   - e) Registration No: : ....

8. **Total amount Claimed** : ....

Schedule of Expenses given overleaf.

In support of the above claim, I enclose 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. Receipts and Pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner/ Surgeon demanding such Pathological test.
4. Surgeon's certificate stating nature of operation performed and Surgeon's bill and receipt.
5. Attending Doctor's /Consultant's / Specialist's / Anaesthetist's bill and receipt and certificate regarding diagnosis.
6. In case of Domiciliary Hospitalisation receipt from a qualified nurse who attended the patient at his/her residence duly supported by a certificate from attending Medical Practitioner.
7. Certificate from the attending Medical Practitioner giving reasons for treatment under Domiciliary Hospitalisation Clause of policy.
8. Certificate from 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 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 Medical Scheme of Insurance.

Dated at .... this the .... day of 200

Signature of the Claimant

IMPORTANT : Since it is a pre-requisite for admission of claim under the policy that the Hospital / Nursing Home / Clinic where the insured person was admitted, is registered with Local Authorities, it is necessary for the claimant to ensure that the Hospital / Nursing Home / Clinic indicates the Registration Number on the Bill - cum - Receipt issued.

For Office Use :

Date of Claim :