NATIONAL INSURANCE COMPANY LIMITED

Registered & Head Office :3, Middleton Street, Kolkata 700 071.

Claim No.

HOSPITALISATION AND DOMICILIARY HOSPITALISATION BENEFIT POLICY

CLAIM FORM

Issuance of this Form does not amount to admission of any liability under the claim on the part of the insurers.
YOU ARE ADVISED TO FILL EACH AND EVERY COLUMN OF THIS CLAIM FORM and give all information correctly and completely to enable the company to process your claim promptly

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

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 : _____
   e) Telephone Number : _____
   f) E-Mail Address : _____

3. Policy No. in Full : _____

   Policy Period : From _____ To _____

4. Nature of Disease/ Illness contracted
Or Injury suffered _____

5. Date of injury sustained or Disease/
Illness first detected ___ ___ ___ ___ ___ ___ ___ ___
(Date) (Month) (Year)

6. a) Name & 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 : ___ ___ ___ ___ ___ ___ ___ ___
(Date) (Month) (Year)

c) Date of Discharge : ___ ___ ___ ___ ___ ___ ___ ___
(Date) (Month) (Year)

8. If the claim is for Domiciliary Hospitalization
Please Indicate

a) Date of Commencement of treatment : ___ ___ ___ ___ ___ ___ ___ ___
(Date) (Month) (Year)

b) Date of Completion of treatment : ___ ___ ___ ___ ___ ___ ___ ___
(Date) (Month) (Year)

c) Name & Address of attending
Medical Practitioner : _____

d) Telephone No. : : _____

e) Registration No. : _____

9. Are you at present covered under any other similar type of scheme like P.A. Cancer Insurance, Mediclaim (Individual/Group), Health Insurance, etc. If yes, please give particulars of each.

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.

b) (i) Is this the first claim under this policy? Yes/No
(ii) If no, please quote previous claim number and details in given space below.

_____

I have incurred Rs. _____ on the treatment of disease/illness/accident referred to above, as per the details given by me in the Schedule of Expense given below.

Details of Hospital/Nursing Home/Clinic Bill

No.	PARTICULARS	AMOUNT (RS.)
1	Room Charges	
2	Pathology Charges	
3	Surgeon Fees	
4	Anesthesia charges	
5	Consultation Fees	
6	Medicines (from chemist)	

7	**Others**	
	Attach separate sheet if necessary	
	TOTAL	

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/Specialists/ Anesthetist'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 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 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 of Insurance.

I also consent and authorize the 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 the TPA to receive payment from Insurance Company as reimbursement of hospital bill incurred on my treatment.

Dated at _____ this _____day of _____ 200 ___

Signature of the Claimant