



HOSPITALIZATION CLAIM FORM FOR REIMBUREMENT

*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 & Completely
(To Be Filled In Block Letters)*

CLAIM CONTROL NO: _____

1. NAME OF INSURED: _____
 (a) Residential Address: _____

 (b) Tel. No. _____ Mobile No. _____
2. POLICY NO: _____
3. DETAIL OF THE CLAIMANT: _____
 (in respect of whom the claim is made)
 a. Name of claimant: _____
 b. Relationship with insured: _____
 c. Present Age: _____
4. a) Nature of Disease/Illness contracted of injury suffered: _____

 b) Date of Injury, or Disease/Aliment contracted/Detected, for which the expences are Claimed hereby
 i) When 1st detected: _____
 ii) When Cured: _____
 iii) If not Cured, give Complete History _____

5. Name & Address of the hospital/Nursing Home/Clinic admitted to
 i) Date & Time of admission: _____
 ii) Date & Time of discharge: _____
6. Total Amount Claimed: _____

I have on the treatment of Disease/Illness/Injury referred to above. In support of the above claim, I enclose The following documents: **(Please tick the Followings)**

- a. Discharge Summary of the Hospital/Nursing Home
- b. Cash Memo/Bills supported by proper prescriptions.
- c. Receipt, pathological tests reports supported with prescriptions.
- d. Hospital Bill with receipt of payment.
- e. Breakup of each heads of hospital bill.
- f. Any other detail/documents which substantiate the claim
- g. Hospital Declaration Form (Over leaf to be filled by the hospital)

I hereby warrant the truth of the foregoing particulars in every respect & I agree that if I have made of shall make any false of untrue statement of concealment may right to claim reimbursement of the expences 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.

Signature of Insured

Signature of claimant