Reliance Wealth + Health Plan Claim Form Hospital Cash Benefit

(To be filled in BLOCK LETTERS by the Claimant/Principal Insured)

Date D D M M Y Y Y Y

Please answer all questions carefully. Also attach copy of the health card along with identity proof.

Name of the Principal Insured FIRST MIDDLE LAST

Policy number (as on your policy schedule)

Date of Birth D D M M Y Y Y Y Age Gender Male Female

Daily Hospital Cash Benefit Amount Sum Assured Riders Yes No

Correspondence Address/ Usual place of residence FIRST LAST

FLAT NO. BUILDING

ROAD NAME/NO. LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE Pin Code

STD ISD Code LANDLINE MOBILE EMAIL ADDRESS

Name of the Insured person (in respect of whom the claim is made)

Relationship with Principal Insured Date of Birth D D M M Y Y Y Y

Date of injury sustained or disease/illness first detected D D M M Y Y Y Y

Please describe the injury sustained or disease/illness contracted (including cause)

Name of the attending medical practitioner

Address of the attending medical practitioner FLAT NO. BUILDING

ROAD NAME/NO. LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE Pin Code

STD ISD Code LANDLINE MOBILE EMAIL ADDRESS

Fax Qualification Registration No.

Name of Hospital/Nursing Home

Address of Hospital/Nursing Home/Clinic ROOM NO. BUILDING

ROAD NAME/NO. LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE Pin Code

STD ISD Code LANDLINE MOBILE EMAIL ADDRESS

Fax

Date & Time of Admission D D M M Y Y Y Y Time

Date & Time of Discharge D D M M Y Y Y Y Time

Sign & Stamp of treating doctor

No. of Days in Hospital (in a ward other than ICU) No. of Days in ICU

Date & Time of Admission in the ICU D D M M Y Y Y Y Time

Date & Time of Discharge from ICU D D M M Y Y Y Y Time

Date & Mode of Intimation given to the TPA D D M M Y Y Y Y Mode

Pre-authorization approval taken Yes No (Attach proof) If No, please provide reason for the same

Have the police authorities been informed? Yes No (For accident case only)

Have you lodged any claim under this policy or any other health insurance policy including mediclaim, hospital case benefit etc. If yes, please provide the following details

a. Name of the Insurance Company

b. Diagnosis

c. Whether settled/repudiated d. Amount

Schedule of expenses incurred under the following benefits (to be supported by original bills/receipts, memos, discharge summary, hospital report or copies of the original reports attested by TPA authorised official etc.) Please refer to your policy schedule for coverage details. In case of insufficient space, please attach an additional sheet.

CLAIMS/HCBWH/Ver 3/Jan2021

Hospital Cash Benefit

ICU

Recuperation Benefit

Major Surgical Benefit

Critical Illness

Signature of the Insured Person

Place

Date D D M M Y Y Y Y

In support of the above claim, I enclose the following documents (please indicate by tick mark).

1) Bill, Receipt and Discharge Certificate/Card from the hospital ☐
2) Pathological test report from a Pathologist ☐
3) Attending Doctor's/Surgeon's certificate supporting hospitalisation (including ICU admission if any), diagnosis and treatment ☐

Bank Account Details of Claimant/Appointee in case the proposer died in the laspe period (Please note that all the payments would be made only through direct transfer to the Bank Account, hence cancelled cheque is to be attached)

Name as per Bank Records F I R S T M I D D L E L A S T

B A N K N A M E B R A N C H N A M E

A C C O U N T N O. I F S C C O D E

Declaration by Claimant

I have undergone treatment of the illness or bodily injury referred above as per the details given by me. I hereby warrant the truth of the foregoing particulars in every respect and I further confirm and warrant that there is no other information relevant to my right to claim which would have a bearing upon your consideration of my claim and with which you ought to be acquainted. I hereby give my consent and authority for you to seek medical information (indoor case papers, reports, documents, including photocopies thereof, pertaining my admission/treatment) from any Hospital or Doctor from which/whom I have at any time sought or shall seek medical attention concerning any disease/sickness, ailment or injury, which affects my physical or mental health.

Signature of the Claimant

Date D D M M Y Y Y Y

Declaration by Primary Insured

I hereby warrant the truth of the foregoing particulars in every respect of the above claim. I hereby confirm that the amount payable to me under the coverage terms and conditions would, when received constitute full and final discharge towards this claim.

Signature of the Primary Insured

Date D D M M Y Y Y Y

Documents check list for health plan

Hospital Cash Benefit

1) Hospitalisation claim form duly signed by the insured person(s)/policyholder ☐
2) Original or copies of the original reports attested by TPA authorised official discharge card/discharge summary ☐
3) Original or copies of the original reports attested by TPA authorised official reports of all investigations ☐
4) Hospital Bill and receipts for payment ☐
5) Please enclose a case summary report giving history of the case ☐
6) Copy of FIR (in case of accident) ☐

The above list is not exhaustive; TPA/RNLIC may request additional documents/information, if any, for processing the claim.

Critical Conditions (25) Rider/Major Surgical Benefit

1) Specialist doctors certificate confirming the diagnosis and when the symptom first occurred
2) Relevant investigation reports (Radiology, Pathology etc) confirming the diagnosis
3) Hospital admission & discharge card/certificate plus all documents as per 1 to 5 in respect of hospitalisation as above

CIN: U66010MH2001PLC167089

CLAIMS/HCBWH/Ver 3/Jan2021

Reliance Wealth + Health Plan

Date D D M M Y Y Y Y

Attending Medical Practitioners Statement - to be answered by the attending medical practitioner in complete.

(To be filled in case discharge summary does not contain the following information)

Name of the Insured Person FIRST MIDDLE LAST

Age of the Insured

Correspondence Address/ Usual place of residence FLAT NO. BUILDING

ROAD NAME/NO. LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE Pin code

STD ISD Code LANDLINE MOBILE EMAIL ADDRESS

Nature of disease suffered by insured

What treatment was given/operation performed, if any?

When did the first symptom appear D D M M Y Y Y Y

Is the present ailment a complication of a pre-existing disease? Yes No If yes, please give details

Does the treatment given necessitate admission? Yes No

Is the disease/disorder congenital in nature? Yes No

What was the history reported to you at the time of consultation?

For accident case

Are the injuries traceable to any pre-existing ailment/infirmities? Yes No

Was he/she under the influence of intoxicants or drugs at the time of accident? Yes No

Was any medico legal case filed? Yes No

Have you provided medical treatment to the insured previous to this treatment? Yes No If yes, specify the details

Signature of the Medical Practitioner

Date D D M M Y Y Y Y

Name of attending Medical Practitioner

Dr. FIRST MIDDLE LAST

Address of the Medical Practitioner/Hospital/Clinic ROOM NO.

ROAD NAME/NO. LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE Pin Code

STD ISD Code LANDLINE Fax EMAIL ADDRESS

Qualification Registration No.

Please find attached a short case history of the patient.

CIN: U66010MH2001PLC167089

CLAIMS/HCBWH/Ver 3/Jan2021