Claim form major surgical benefit

(To be filled in block letters by the Claimant/Principal Insured)

Date D D M M Y Y Y Y

In support of the above claim, I enclose following details & documents (Please indicate by tick mark)

S. No.	POLICY No.	
1.	**Name of the Policy holder**	
(a)	Date of commencement of base plan	
(b)	Date of commencement of major surgical rider	
2.	**Details of the insured person: (in respect of whom claim is made)**	
(a)	Relationship with the insured	
(b)	Present completed age	
(c)	Gender	
(d)	Occupation	
3.	**Sum Assured**	
4.	**Date of Injury sustained or Disease/Illness First detected**	
5.	**Nature of Disease/illness contracted or injury suffered**	
6.	**Name of the surgical procedure performed**	
7.	**Name of the attending Medical Practitioner**	
(a)	Address of the attending Medical Practitioner	
(b)	Telephone No.	
(c)	Qualification	
(d)	Registration No.	
8.	**Name & Address of the hospital/nursing home/clinic**	
(a)	Registration Number	
(b)	No. of beds in the Hospital	
(c)	Date of Admission	
(d)	Date of Discharge	
(e)	Date of Surgery	
9.	**Have you lodged any claim under this policy or any other health insurance policy including Mediclaim, critical illness etc? If yes, please provide the following details.**	
(a)	Name of the company	
(b)	Diagnosis	
(c)	Whether settled/repudiated	
(d)	Amount	
10.	**Was any benefit paid under this policy for this rider earlier?**	☐ Yes ☐ No If Yes, please mention
(a)	Date of Payment	
(b)	Sum Assured Paid	

1. Bill, Receipt and Discharge certificate/card from the Hospital ☐
2. Pathological test report from a Pathologist ☐
3. Attending Doctor?/Surgeons certificate stating nature of operation performed ☐
4. Cancelled cheque leaf & bank passbook/bank statement ☐

I hereby declare that the statements made in this claim form by me are true and correct to the best of my knowledge and belief.

Signature of Witness

Signature of the Life Assured

Date D D M M Y Y Y Y

Name of Witness FIRST MIDDLE LAST

Address C/o. 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

Declaration by the person completing this claim form

Reliance Nippon Life Insurance requires that this form is completed by the Life Assured. If this is not possible because the Life Assured does not read, write or speak English, then this form may be completed by another person who must complete the following declaration.

I have explained the contents of this form to the Life Assured and endeavoured to ensure that the contents have been fully understood. I have accurately recorded the responses to the information sought by this Claim form and I have read the responses back to the Life Assured and confirmed that they are correct.

Name of Declarant FIRST MIDDLE LAST

Address of Declarant 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 Claimant FIRST MIDDLE LAST

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

Bank Account Details

Claimant Name as per bank records FIRST MIDDLE LAST

BANK NAME BRANCH NAME

ACCOUNT NO. IFSC CODE MICR CODE

Payment will be credited to the given bank account except in the case where the banks are not participating in Electronic Clearing

Signature of the Claimant

Date D D M M Y Y Y Y

Signature of Declarant

For Internal Use: To be filled by the Branch CCE	
Claimant Name/Relationship	
Claimant Contact No.	
Name of the Branch CCE	
SAP Code of the CCE	
Contact No. of the CCE	
Email ID of the CCE	
Date of receiving the Claim Form at the branch	
Signature of the CCE	

CIN: U66010MH2001PLC167089

CLAIMS/MSB/Ver3/Jan2021