

**CLAIM FORM – HOSPITAL CASH BENEFIT
(To be filled in block letters by the Claimant/Principal Insured)**

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

1. Name of the Principal Insured: _____

2. Policy no. (As on your policy schedule): _____

Date of commencement of the policy: _____ Policy Term: _____

Date of Birth: _____ Age: _____ Gender: M / F Riders: _____

Daily Hospital Cash Benefit Amount: _____ Sum Assured: _____

3. Address of the Principal Insured: _____

Telephone: _____ Mobile: _____

E-Mail: _____

4. Name of the Insured person (in respect of whom the claim is made): _____

Relationship with Principal insured _____ Date of Birth/ Age last Birthday: _____

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

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

7. Name of the attending Medical practitioner: _____

8. Address of attending Medical practitioner: _____

Telephone: _____ Mobile: _____

E-Mail: _____ Fax _____

Qualification _____ Registration no _____



Corporate Office: 9th & 10th Floor, Building No.2, R-Tech Park, Nirlon Compound, Next to Hub Mall, Gurgaon (East), Mumbai - 400063 Tel: 022 30002000 Fax: 022 3000222

Registered Office: H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai, Maharashtra - 400710

Reliance Life Insurance Company Limited is a licensed life insurance company registered with the Insurance Regulatory and Development Authority (Registration No: 121) in accordance with the provisions of the Insurance Act 1938

9. Name of Hospital/ Nursing home: _____

10. Address of Hospital/ Nursing home/Clinic: _____

Telephone: _____ Mobile: _____

E-Mail: _____ Fax _____

11. Date & time of admission: _____ Date & time of discharge: _____

12. No of Days in Hospital (In a ward other than ICU): _____

13. No of Days in ICU: _____ 14. Date & time of admission in the ICU: _____

15. Date & time of discharge from ICU: _____

16. Date and mode of intimation given to the TPA _____

17. Pre-authorization approval taken: Yes / No (Attach proof): _____

If No, please provide reason for the same _____

18. Have the police authorities been informed? Yes / No _____

(For accident case only)

19. 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 insurance company: _____

b. Diagnosis: _____

c. Whether settled/repudiated: _____

d. Amount: _____

20. 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 authorized official etc.) Please refer to your policy schedule for coverage details. In case of insufficient space, please attach an additional sheet.

Hospital cash benefit _____

ICU _____

Recuperation Benefit _____

Major surgical Benefit _____

Critical illness _____

Signature of insured person: _____

Date: _____

Place: _____

In support of the above claim, I enclose 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 hospitalization (including ICU admission if any), diagnosis and treatment.

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 here by 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 or 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 claimant:**Date:**

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:**

Documents check list for health plan:**Hospital Cash Benefit:**

1. Hospitalization claim form duly signed by the insured person(s)/policy holder.
2. Original or copies of the original reports attested by TPA authorized official discharge card/discharge summary.
3. Original or copies of the original reports attested by TPA authorized 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/RLIC 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 hospitalization as above.

Attending Medical Practitioners Statement

To be answered by attending medical practitioner in complete.
(To be filled in case discharge summary does not contain the following information)

1. Name of the Insured Person: _____ 2. Age of the Insured: _____

3. Address of the Principal Insured: _____

Telephone: _____ Mobile: _____

E-Mail: _____

4. Nature of disease suffered by insured: _____

5. What treatment was given /operation performed, if any?

6. When did the first symptom appear: _____

7. Whether the present ailment is a complication of pre-existing disease? If yes, please give details:

8. Whether the treatment given necessitates admission: _____

9. Whether the disease/disorder is Congenital in nature? _____

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

For accident case:

11. Are the injuries traceable to any pre-existing ailment/infirmities?

12. Was he/she under the influence of intoxicants or drugs at the time of accident?

13. Any medico legal case filed?

14. Have you provided medical treatment to the insured previous to this treatment? If yes, specify the details

Signature of the Medical Practitioner _____ Date: _____

Name of attending Medical practitioner: Dr _____

Address of the Medical practitioner/ Hospital/ Clinic: _____

E-Mail: _____ Fax _____

Qualification _____ Registration no _____

Please find attached a short case history of the patient.