

Reliance Wealth + Health Plan

CLAIM FORM – Critical Conditions (25) Rider
(To be filled in block letters by the Claimant/Principal Insured)

1. Name of the Insured Person: _____

2. Correspondence Address/ Usual place of residence: _____

_____ Phone No.: _____

3. Policy Number: _____

4. Mention full particulars of all other Policies on your life, taken with our company:

	Policy Number	Date of Commencement	Sum Assured
1			
2			
3			
4			
5			

5. Date of diagnosis / illness: _____

6. Details of Diagnosis: _____

7. When did you first complain of illness? (Day/ Month) _____

8. What was the nature of complaint? _____

9. Name and Address of the Doctor who diagnosed/treated your illness initially:

10. Name and Address of the Hospital:

11. Sign & stamp of treating doctor

ISO 9001:2008

Reliance Nippon Life Insurance Company Limited (formerly known as Reliance Life Insurance Company Limited). IRDAI Registration No: 121. Registered Office: H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai, Maharashtra 400710. For more information or any grievance, 1. Call us between 9am to 6pm, Monday to Saturday on our Toll Free Number **1800 102 1010** or 2. Visit us at **www.reliancenipponlife.com** or 3. Email us at: **mlife.customerservice@relianceada.com**. Trade logo displayed above belongs to Anil Dhirubhai Ambani Ventures Private Limited & Nippon Life Insurance Company and used by Reliance Nippon Life Insurance Company Limited under license.

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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.