

Reliance Wealth + Health Plan Claim Form – Hospital Cash Benefit

Date DDMMYYYY

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

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

Name of the Principal Insured F I R S T LAST

Policy number (as on your policy schedule)

Date of Birth DDMMYYYY Age Gender Male Female

Daily Hospital Cash Benefit Amount Sum Assured Riders Yes No

Correspondence Address/ Usual place of residence F I R S T LAST FLAT NO. BUILDING ROAD NAME / NO. LANDMARK 1 LANDMARK 2 CITY / VILLAGE STATE Pincode

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 DDMMYYYY

Date of injury sustained or disease/illness first detected DDMMYYYY

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

Name of the attending medical practitioner

Address of the attending medical practitioner F I R S T LAST FLAT NO. BUILDING ROAD NAME / NO. LANDMARK 1 LANDMARK 2 CITY / VILLAGE STATE Pincode

STD ISD Code LANDLINE MOBILE EMAIL ADDRESS

Fax Qualification Registration No.

Name of Hospital/Nursing Home

Address of Hospital/Nursing Home/Clinic R O O M N O. BUILDING ROAD NAME / NO. LANDMARK 1 LANDMARK 2 CITY / VILLAGE STATE Pincode

STD ISD Code LANDLINE MOBILE EMAIL ADDRESS

Fax

Date & Time of Admission DDMMYYYY Time

Sign & Stamp of treating doctor

Date & Time of Discharge DDMMYYYY Time

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

Date & Time of Admission in the ICU DDMMYYYY Time

Date & Time of Discharge from ICU DDMMYYYY Time

Date & Mode of Intimation given to the TPA DDMMYYYY 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.



Reliance Wealth + Health Plan

Date DDMMYYYY

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 LAST

Age of the Insured

Correspondence Address/ Usual place of residence FLAT NO. BUILDING LANDMARK 1 LANDMARK 2 CITY/VILLAGE STATE Pincode 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 DDMMYYYY

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 DDMMYYYY

Name of attending Medical Practitioner

Dr. FIRST LAST

Address of the Medical Practitioner/Hospital/Clinic ROOM NO. BUILDING LANDMARK 1 LANDMARK 2 CITY/VILLAGE STATE Pincode STD ISD Code LANDLINE Fax EMAIL ADDRESS

Qualification Registration No.

Please find attached a short case history of the patient.

Empty box for case history

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: rnlife.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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