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

_____

_____

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12. Date of Admission & Time: _____

13. Date of Discharge & Time: _____

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 | | | | | | | | | | | | | | | 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						

I am enclosing herewith:

1. Original reports including all investigation reports: ☐
2. Doctor / hospital certificate/s: ☐
3. Others:_____

Declaration by 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 Insured

Dated:

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.

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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?

_____

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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.

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