RELIANCE NIPPON LIFE INSURANCE

A RELIANCE CAPITAL COMPANY

Reimbursement Claim Form

CLAIM FORM - PART A
TO BE FILLED IN BY THE INSURED
The issue of this Form is not to be taken as an admission of liability

(To be filled in BLOCK LETTERS)

DETAILS OF THE PRIMARY INSURED

Policy No. **SI No./Certificate No.**

Company/TPA ID No.

Name FIRST LAST

Correspondence Address/ Usual place of residence FIRST LAST FLAT NO.

BUILDING ROAD NAME/NO.

LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE

Pincode MOBILE 1 MOBILE 2

STD ISD Code LANDLINE EMAIL ADDRESS

DETAILS OF INSURANCE HISTORY

Currently covered by any other Mediclaim/Health Insurance ☐ Yes ☐ No

Date of commencement of first insurance without break (copies of policies to be attached) DDMMYEAR

If yes, Company name **Policy No.**

Sum Insured (Rs.) **Have you been hospitalised in the last 4 years?** ☐ Yes ☐ No

Date DDMMYEAR **Diagnosis**

Previously covered by any other Mediclaim/Health insurance ☐ Yes ☐ No **If yes, Company name**

DETAILS OF INSURED PERSON HOSPITALISED

Name FIRST LAST

Gender ☐ Male ☐ Female **Age** ☐☐ Years ☐☐ Months **Date of Birth** DDMMYEAR

Relationship to Primary Insured ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please Specify)

Occupation ☐ Service ☐ Self-Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please Specify)

Address (if different from above) FIRST LAST FLAT NO.

BUILDING ROAD NAME/NO.

LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE

Pincode MOBILE 1 MOBILE 2

STD ISD Code LANDLINE EMAIL ADDRESS

DETAILS OF INSURED PERSON HOSPITALISED

Name of the hospital where admitted

Room category occupied ☐ Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room

Hospitalisation due to ☐ Injury ☐ Illness ☐ Maternity

Date of injury/Date disease first detected/Date of delivery DDMMYEAR

Date of admission DDMMYEAR **Time** MMHH

Date of discharge DDMMYEAR **Time** MMHH

If injury, give cause ☐ Self-Inflicted ☐ Road traffic accident ☐ Substance abuse/Alcohol consumption

If Medico legal ☐ Yes ☐ No **Reported to police** ☐ Yes ☐ No **MLC report & police FIR attached** ☐ Yes ☐ No

System of medicine

(Important: Please Turn Over)

DETAILS OF THE CLAIM

Details of the treatment expenses claimed

Pre-hospitalisation expenses		Hospitalisation expenses	
Post-hospitalisation expenses		Health check-up cost	
Ambulance charges		Others (code)	
		Total	

Pre-hospitalisation period ☐☐ Days Post-hospitalisation period ☐☐ Days

Claim for domiciliary hospitalisation ☐ Yes ☐ No (If yes, provide details in the annexure)

Details of lump cum/Cash benefit claimed

Hospital daily cash		Surgical cash	
Critical illness benefit		Convalescence	
Pre/Post hospitalisation		Others	
Lump sum benefit		**Total**	

CLAIM DOCUMENTS SUBMITTED (CHECK LIST)

☐ **Claim form duly signed**	☐ **Copy of the claim intimation**	☐ **Hospital discharge summary**	☐ **Doctors request for investigation**
☐ **Hospital main bill**	☐ **Hospital break-up bill**	☐ **Operation theatre notes**	☐ **Doctors prescriptions**
☐ **Hospital bill payment receipt**		☐ **Pharmacy bill**	☐ **ECG**
☐ **Investigation reports (Including CT/MRI/USG/HPE)**	☐ **Others**		

Details of Bills Enclosed

Sl No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1		D D M M Y Y Y Y		Hospital Main Bill	
2				Pre-hospitalisation Bills __ Nos	
3				Post-hospitalisation Bills __ Nos	
4				Pharmacy Bills	
5					
6					
7					
8					
9					
10					

DETAILS OF THE PRIMARY INSUREDS BANK ACCOUNT

PAN Card No. ☐☐☐☐☐☐☐☐☐☐ **Account No.**

Bank name and Branch B A N K N A M E

B R A N C H N A M E

Cheque/DD Payable details **IFSC Code**

Declaration by the Insured

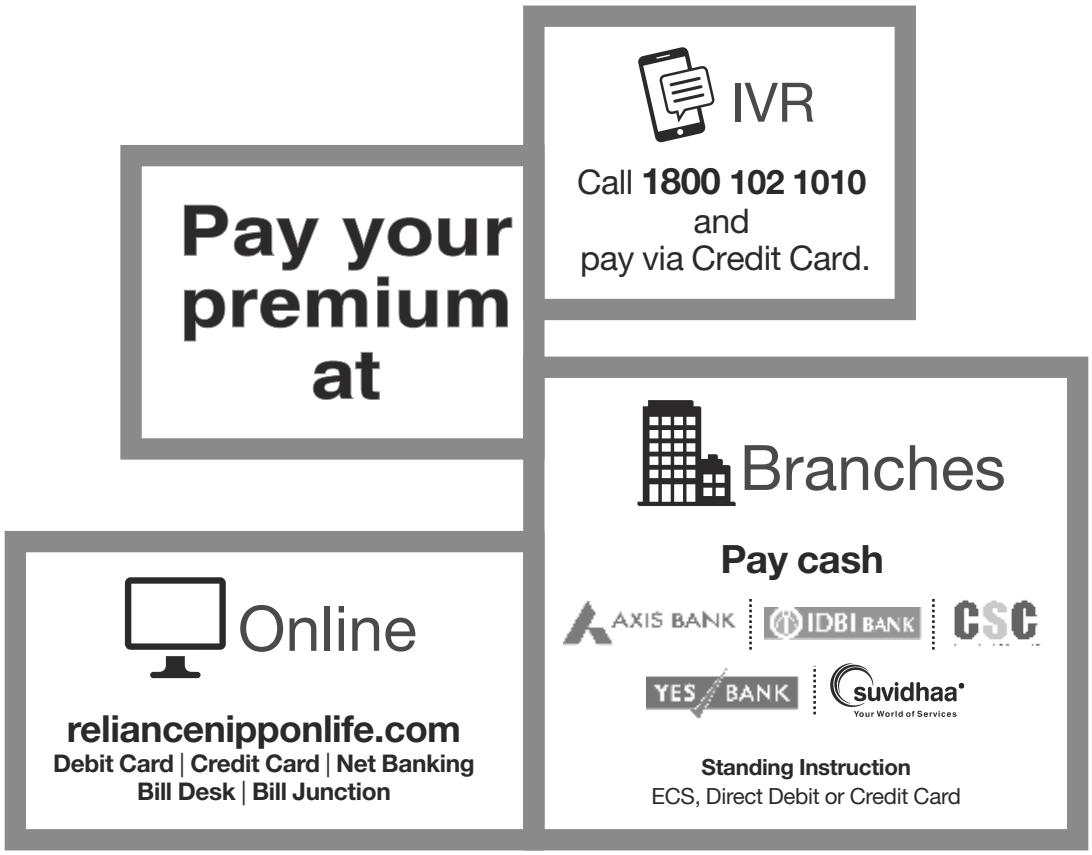
I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to claim reimbursement shall be forfeited. I also consent & authorise TPA/Insurance company, to seek necessary medical information/documents from any hospital/Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills/receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalisation claim, if any.

Date D D M M Y E A R **Place**

Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the Insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) SI. No./Certificate No.	Enter the social insurance number or the certificate number of the social health insurance scheme	As allotted by the organisation
c) Company TPA ID No.	Enter the TPA ID No.	License number as allotted by IRDAI
d) Name	Enter the full name of the policyholder	Surname. First Name. Middle Name
e) Address	Enter the full postal address	Include Street, City and Pin Code
SECTION B DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim /Health Insurance?	Indicate whether currently covered by another Mediclaim/Health Insurance	Tick Yes or No
b) Date of commencement of first insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company name	Enter the full name of the insurance company	Name of the organisation in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum insured	Enter the total sum insured as per the policy	In rupees
d) Have you been hospitalised in the last	Indicate whether hospitalised in the last 4 years	Tick Yes or No
4 years		
Date	Enter the date of hospitalisation	Use mm-yy format
Diagnosis	Enter diagnosis details	Open text
e) Previously Covered by any other Mediclaim/Health Insurance?	Indicate whether previously covered by any other Mediclaim/Health Insurance	Tick Yes or No
f) Company name	Enter the full name of the insurance company	Name of the organisation in full
SECTION C DETAILS OF THE INSURED PERSON HOSPITALISED		
a) Name	Enter full name of the patient	Surname. First Name. Middle Name
b) Gender	Indicate gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years & months
d) Date of Birth	Enter Date of Birth of the patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with the policyholder	Tick the right option. If others, please specify
f) Occupation	Indicate occupation of the patient	Tick the right option. If others, please specify
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Phone No.	Enter the phone number of the patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of the patient	Complete e-mail address
SECTION D DETAILS OF HOSPITALISATION		
a) Name of the hospital where admitted	Enter the name of the hospital	Name of the hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalisation due to	Indicate reason of hospitalisation	Tick the right option
d) Date of injury/date of diseases first detected/Date of delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh-mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh-mm format
i) If injury give cause	Indicate cause of injury	Tick the right option
If Medico legal	Indicate whether the injury is Medico legal	Tick Yes or No
Reported to police	Indicate whether police report was filed	Tick Yes or No
MLC Report & police FIR attached	Indicate whether MLC Report & police FIR attached	Tick Yes or No

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the Insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION E DETAILS OF CLAIM		
a) Details of treatment expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for domiciliary hospitalisation	Indicate whether claim is for domiciliary hospitalisation	Tick Yes or No
c) Details of lump sum/Cash benefit claimed	Enter the amount claimed as lump sum/Cash benefit	In Rupees (Do not enter paise values)
d) Claim documents submitted (Check-list)	Indicate which supporting documents are submitted	Tick the right option
SECTION F DETAILS OF THE BILLS ENCLOSED		
Indicate which bills are enclosed with the amount in Rupees		
SECTION G DETAILS OF PRIMARY INSUREDS BANK ACCOUNT		
a) PAN Card No.	Enter the permanent account number	As allotted by the Income Tax department
b) Account No.	Enter the Bank account number	As allotted by the Bank
c) Bank name & branch	Enter the Bank name along with the branch	Name of the Bank in full
d) Cheque/DD Payable details	Enter the name of the beneficiary, the cheque/ DD should be made out to	Name of the individual/organisation in full
e) IFSC Code	Enter the IFSC code of the Bank branch	IFSC code of the Bank branch in full
SECTION H DECLARATION BY THE INSURED		
Read declaration carefully and mention date in (dd/mm/yy format), place (open text) & sign.		



Reliance Life Insurance Company Limited IRDAI Registration No. 121.
Insurance is the subject matter of the solicitation.

Mktg/Premium Payment-Sticker/V1/April 2015.