RELIANCE General Insurance
Anil Dhirubhai Ambani Group

MEDICLAIM INSURANCE POLICY CLAIM FORM

(Issuance of this form does not imply acceptance of the liability)

PLEASE ANSWER EVERY QUESTION AND FULLY

1. Name of the Insured (in whose name the policy is issued)													
2. Customer ID													
3. Address of the Insured	Plot No / Door No.		Building name										
	Road												
	Area												
	City		Pin code										
	State												
	Phone No.												
	E-mail Id												
4. a) Name of the insured person (in respect of whom the claim is made) b) Relationship to the insured c) Present completed age d) Occupation													
5. Date of injury sustained or disease / illness first detected													
6. a) Name & address of the attending medical practitioner b) Qualification & telephone no c) Registration no.													
7. Name & address of the hospital / nursing home / clinic 7A. Describe the disease.													
8. Date of admission 9. Date of discharge													

10. If the claim is for domiciliary hospitalisation, please indicate	
a) Date of commencement of treatment	a)
b) Date of completion of treatment	b)
c) Name & address of attending medical practitioner	c)
d) Telephone no.	d)
e) Registration no.	e)

11. Schedule of expenses incurred by the claimant under hospitalisation / domiciliary hospitalisation (to be supported by bills / receipts, cash memos etc.)

	Expenses incurred in the hospital	Pre hospitalisation expenses (Rs)	Post hospitalisation expenses (Rs)
Hospitalisation Benefit			
Domiciliary hospitalisation		Not applicable	Not applicable

I have incurred on the treatment of disease Rs.

(Summary is enclosed)

Detailed note on the happenings :

Signature of the Insured