THE ORIENTAL INSURANCE COMPANY LIMITED

Regd. Office : Oriental House, P.B. No. 7037, A-25/27, Asaf Ali Road, New Delhi 110002

Claim No. ……

Issuing Office

GOOD HEALTH INSURANCE POLICY -CLAIM FORM

Issuance of this form does not amount to admission of any liability under the claim on the part of the insurers.

Please give the following information correctly and completely to enable the company to process your claim promptly.

				For office use only
1.	Name of the Insured (In whose name policy is issued)	(Surname)	(Initial)	
2.	Details of the Insured Person (In respect of who claim is made			
a	Name & relationship to the insured			
b	Present completed age	DOB	Age	
c	Occupation			
d	Residential Address Telephone No.			
3.	Policy No.			
4.	Nature of Disease/illness contracted or injury suffered			
5.	Date of injury sustained or disease/illness first detected			
a	Name and address of the attending Medical Practitioner			
b	Qualification & Telephone No.			
c	Registration No.			
6a	Name & Address of the Hospital / Nursing Home Clinic			
b	Date of admission			
B	Date of Discharge			

I have incurred on the treatment of Disease / illness / Accident referred to above, the expenses as per the details given by me in the Schedule of Expenses given overleaf.

In support of the above claim I enclose following documents (please indicate by)

1. Discharge certificate/card from the Hospital.
2. Bill, Receipt and Cash Memos from the Hospital/Chemist(s), supported by the proper prescription.
3. Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practioner/Surgeon demanding such Pathological test.
4. Surgeon s certificate stating nature of operation performed and Surgeon/s bill and receipt.
5. Attending Doctor s Consultant s / Specialist/ Anaesthestist s bill and receipt and certificate regarding diagnosis.
6. Certificate from the attending Medical Practitioner / Surgeon that the patient is fully cured.

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement suppression or concealment my right to claim reimbursement of the said expenses shall be absolutely forfeited I further declare that in respect of the above treatment no benefit are admissible under any other Medical Scheme or Insurance.

Dated at _____this_____day of _____200

Signature of the Claimant

FOR OFFICE USE

POLICY NUMBER _____SUM INSURED OPTED_____ CLAIM NO. _____

SCHEDULE OF EXPENSES INCURRED BY THE CLAIMANT			**FOR OFFICE USE ONLY**	
Details of Expenses claimed under Hospitalisation / Domiciliary Hospitalisation (To be supported by Bills/Receipts, Cash memos etc.)		Amount Claimed (1)	Amount not payable (2)	Net Payable (1) – (2) = (3)
1	**Hospitalisation Benefits:**			
I	Room, Board Nursing expenses including registration and service charges provided by Hospital for ____days @ Rs _____ per day			
ii	IC Unit for _____ days @ Rs _____ per day			
iii	Emergency Ambulance charges			
	Total Amount under i, ii & iii			
2	Hospitalisation Benefits (Other than Room, Board & Nursing Expenses & ICCU (including pre & post Hospitalization)			
i	Surgeon, Anaesthetists, Medical Practitioner Consultants Specialists fees.			
ii	Anaesthesia Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials & X-rays, Dialysis Chemotheraphy, Radiotherapy coast of pacemaker, artificial limbs & Cost of organs and similar other expenses.			
	Total			
3	Maternity Expenses Benefit Extension			
i	Room, Board Nursing expenses for _____days @ Rs _____per day.			
ii	Gynaecologistg/ Obstetrician/ Surgeon/ Physicial / Anaesthetist Fees _____and Normal delivery, Miscarriage and Abortion, Caesarean Section / Abdominal Opening for extra uterine pregnancy.			
iii	Diagnostic materials, X-Ray, Medicines and drugs, injections etc.			
	Total			

Name of the claimant Signature of the Claimant :

DATE
PLACE

FOR OFFICE ONLY

Prepared by: _____	Total amount payable under the claim Rs	in case entire claim is not admissible reasons thereof
Checked by: _____	Less : Advance / on account payment if any Rs	
Approved by: _____	Net amount of Rs	

Passed for payment of Rs _____.

COMPETENT AUTHORITY