THE ORIENTAL INSURANCE COMPANY LIMITED,

Regd. Office : Oriental House, P.B. No. 7037, A-25/27, Asaf Ali Road, New Delhi - 110 002

Universal Health Insurance Claim Form

Policy No. Claim No.

Issue 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.

1	a) Name of the Insured (Name in full) b) Address c) Occupation	
2	**Details of Earning head of the Family** a) Name b) Covered at S.No. of the policy c) Residential address	
3	**Details of Hospitalisation** a) Name of the Insured (In respect of whom claim is made) b) Relationship to Earning head of the Family c) Present completed age. d) Nature of Disease/illness contracted or injury sustained. e) Date of injury sustained or disease/illness first detected. f) Name and address of the Hospital/Nursing Home. g) Regd. No. Of the treating Hospital / Nursing Home (in case of non-registered and non-Govt. Hospital, certificate to be obtained confirming compliance of policy condition no. 2.1 (c)) h) Date of Admission. i) Date of Discharge. j) Details of expenses	

SCHEDULE OF HOSPITALISATION EXPENSES INCURRED			FOR OFFICE USE	
Details of expenses claimed for Hospitalisation (to be supported by Bills, Receipts, Cash Memos alongwith discharge summary)		Amount Claimed Rs	Amount eligible Rs.	Amount Admissible Rs
I	Hospitalisation a) Room Board, Nursing Expenses for days @ Rs per day.			

	b) Unit charges for days @ Rs. Per day.			
II	Non- Surgical & Surgical: a) Surgeon & Anaesthetist fees. b) Medical Practitioners, Consultants and specialists fees for consultations No of visits.			
III	a) Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical appliances. b) Diagnostic materials and X-Ray., etc. c) Dialysis, Chemotherapy, Radiotherapy, Cost of pacemaker, Artificial Limbs & Cost of organs and similar expenses. d) Medicines and Drugs. i. Supplied by Hospital ii. Purchased from Chemists.			
4	Details of Accident. a) When did the accident happen (Give date and exact time.) b) Where did the accident happen c) Give full description of the accident, its cause and injuries sustained. d) State date, time and place of death. e) Give names and addresses of two persons who witnessed the accident. f) Was the injured person free from infirmity at the time of accident? If not give particulars. g) Was the injured person under the influence of drugs or alcohol at the time of accident? h) Name and address of the hospital where the injured person was treated after the accident. (Enclose post-mortem report in case of death of insured in addition to other documents)			
5	Details of other health insurance policies covering the above Insured Person.			

I hereby declare that I have incurred on the treatment of Disease/Illness/Accident referred above, the expenses as per the details given by me. In support of this claim, I enclose all relevant bills vouchers and other documents.

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall made any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited and I shall rendered myself liable to any legal action.

Place:

Date Signature of Insured Person Signature of Insured.