The New India Assurance Company Limited

Registered & Head Office: New India Assurance Building, 87, M.G. Road, Fort, Mumbai - 400 001.

MEDICLAIM POLICY (2007)

CLAIM FORM

Claim Number

Issuance of this form does not amount to admission of any liability of under the policy on the part of the Insurers

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

All dates to be entered as Date / Month / Year

1. Name of the Insured: ____________________ ____

(in whose name policy is issued) SURNAME INITIALS

2. Details of the Insured person : ______________________
   (in respect of whom claim is made) :
   (a) Name & Relationship with the Insured : ______________________
   (b) Present Completed Age : ______________________
   (c) Occupation : ______________________
   (d) Residential Address : ______________________
   ____
   (e) Bank Details
   (i) Account No ______________________
   (ii) Name of the Bank - ______________________
   (iii) Branch :______________________
3. Policy Number (in Full) : __ ____ ____
4. Nature of Disease contracted/Ailment suffered or injury sustained ______________________
5. Date on which injury was sustained/Disease Or ailment first detected :______________________
6. (a) Name and Address of the attending : ______________________
   Medical Practitioner : ______________________
   Pin Code ______________________
   State/ U. Territory ______________________
   (b) Qualification & Telephone No. : ______________________
   (c) Registration No. : ______________________

(d) Name & Address of the Hospital/Nursing Home / Clinic : _____
_____
_____
Pin Code_____
State / U. Territory_____
PAN of Hospital_____
Registration No._____

(e) Date of Admission : _____

(f) Date of Discharge : _____

6. Are you at present covered under any other similar type of scheme like Personal Accident, Cancer Insurance, Mediclaim (Individual or Group), Health Insurance and the like. If Yes. Please give particulars of each

Sr. No.	Content	Details
	Name of Insurer	
	Insurance Scheme	
	Policy No.	
	Period of cover	
	Claim Amt. Recd./receivable	

(a) Is this the first year of coverage under Mediclaim Policy? Yes / No.

If no, since when have you been continuously insured under Mediclaim Policy. Give details

Year Policy No.	Insurer	Policy No.

(b) (i) Is this the first claim under this policy ? **Yes/No**

(ii) If no, please quote Previous claim details

Year	Policy No.	Insurer	Disease/Ailment/Injury details	Amount claimed and receivable or received

In support of the above claim, I enclose the following original documents (Please indicate by √)

1. Bill, Receipt and Discharge certificate / card from the Hospital.
2. Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.
3. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests /pathological
4. Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.
5. Attending Doctor's/ Consultant's/ Specialist's / Anaesthetist's bill and receipt, and certificate regarding diagnosis.
6. Certificate from attending Medical Practitioner / Surgeon that the patient is fully cured.

Summary of expenses incurred for which original bills / receipts / cash memos are enclosed.

Total of Hospital Bill	Rs. _____
Consultant's /Surgeon's /Anesthetist's Fees	Rs. _____
Diagnostics Tests	Rs. _____
Medicines purchased from chemists	Rs. _____
Other expenses not included above (specify)	Rs. _____
Grand Total	Rs. _____

DECLARATION

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 of any fact, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are availed or claimed under any other Medical Scheme or Insurance.

I ALSO CONSENT AND AUTHORISE THE NEW INDIA ASSURANCE COMPANY LIMITED & THIRD PARTY ADMINISTRATOR TO SEEK MEDICAL INFORMATION FROM ANY HOSPITAL / MEDICAL PRACTITIONER WHO HAS AT ANY TIME ATTENDED ON ME.

I authorize TPA to make payment of the claim admissible as per terms, conditions and limitations of the policy to the **Hospital** on my behalf for full and final settlement of hospital bills.

I also authorize TPA to receive payment from the insurance company as reimbursement of hospital bills incurred on my / the insured person's treatment.

Dated at...(place)…… this…… day of...(month)…….200

Signature of the Claimant

ELECTRONIC CLEARANCE SYSTEM FORM

Name of Account Holder

Name of Bank

Branch Name

Branch Address

Type of Account:

Account Number

IFSC

Important information to the Policy holder / claimants opting for NEFT:

1. All the information mentioned above mandate form should be filled correctly.
2. The policy holder / claimant should also submit either the Photocopy of cheque leaf or the Photocopy of the page of the passbook / cheque book where details of the Account Holder Name, IFSC, Account Number are mentioned.
3. The account of the policy holder / annuitant should be operational at the time of receipt of policy payment.
4. Before submitting the mandate form, the policyholder/ claimant should confirm from his bank that it is NEFT enabled.
5. Policy holder's/ claimants' name under the policy should match with that of Bank A/c, else it is likely to be rejected.

Declaration

1. I hereby declare that the information furnished in this ECS Form is true & correct to the best of my knowledge & 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.
2. I agree that I shall not hold TPA/Insurance Company responsible for delay or non-receipt of the payment for any reason whatsoever after issue of the instructions for payment by Insurer/TPA based on the above.
3. As per the revised RBI guidelines, Canceled cheque should have pre-printed name of account holder.

Date:
Place:

Signature of the Policy Holder

----------SAMPLE CHEQUE FORMAT ----------

Note: Claims Number / Policy number / MDID number to be mentioned on cancel cheque and Please enclose the cancelled cheque of your bank account for our record; your banker should be a participant of NEFT/RTGS Facility.