Hospital Cash/Medical Expenses **Claim Form**

WITH YOU ALWAYS

IMPORTANT:
1. Issuance of this form is not an admission of Liability or a waiver of the terms, conditions and exceptions of the insurance contract.
2. If the space provided is insufficient, please attach additional sheets.

Policy No. ____________ **Claim No.** ____________

1. DETAILS OF INSURED

Name ____________ (First Name / Middle Name / Surname)

Address ____________

City ____________

State ____________ PIN ____________

Phone (O) ____________ (R) ____________

Mobile ____________

E-mail ____________

Name of the contact person ____________

Designation ____________

Tel ____________ Fax ____________

E-mail ____________

2. DETAILS OF SICKNESS

Time and Date ____ D D M M Y Y Y Y

Diagnosis ____________

Place and Location ____________

Address ____________

City ____________

State ____________ PIN ____________

3. TREATMENT DETAILS

Name of the Attending Doctor ____________

Tel ____________ Fax ____________

E-mail ____________

Date(s) of Consultation D D M M Y Y Y Y

Name of the Hospital(s) (If hospitalized) ____________

Address ____________

City ____________

State ____________ PIN ____________

Tel ____________ Fax ____________

E-mail ID ____________

Period of hospitalization: From D D M M Y Y Y Y to D D M M Y Y Y Y

Diagnosis/Surgery ____________

4. AMOUNT OF EXPENSES

Please attach a separate sheet if the space is insufficient.

a) In hospital cash (If covered).

From	To	Amount

Have the Police Authorities been informed of this accident? Yes ☐ No ☐

I hereby declare that I have suffered injuries as described above and all the details given are ABSOLUTELY **TRUE AND CORRECT**. I hereby agree to forfeit all my rights to compensation if any of the foregoing facts and/or details are found to be false or incorrect. I further authorise the hospital, doctor diagnostic laboratory, organisation, establishment or any other body or person dealt with in the course of this claim to give any information or document sought for by the Insurance Company.

Date: ____________________

Place: ____________________

Signature of the Insured ____________________

ATTENDING PHYSICIAN'S STATEMENT

PLEASE ANSWER ALL QUESTIONS

Name & Age of Injured Person:

Address

City

State

PIN

Phone (O)

(R)

Fax

Mobile

Details of the Sickness : ____________________

Was the injured person suffering from any disease : ____________________

Was the Claimant hospitalized? If so for what period? ____________________

What treatment was given and Operations performed? ____________________

Give all dates of treatment : ____________________

Home: From ____________ To ____________ Clinic/Hospital: Form ____________ To ____________

Are you his usual medical Attendant ? ____________________

If you have treated him for any previous illness,
Please give details. ____________________

Have other Doctors been in Attendance or Consultation?
If yes, Please give details. ____________________

What is the Prognosis? ____________________

Doctor's Signature ____________ Date ____________ Regn No. ____________

Doctors Name & Seal:

Address

City

State

PIN

Phone (O)

(R)

Fax

Mobile