



# NATIONAL INSURANCE COMPANY LTD.

(Subsidiary of General Insurance Corporation of India)

Regd. Office: 3, MIDDLETON STREET. CALCUTTA – 7000 071

ISSUING OFFICE

## HOSPITALISATION AND DOMICILIARY HOSPITALISATION BENEFIT POLICY CLAIM FORM

Claim No. CL  /  /  /  /  /

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. If the claim is under Personal Accident Insurance, please complete a Personal Accident Claim Form.

1. Name of the Insured: <input type="text"/> <input type="text"/>	For Office use only
(In whose name policy is issued) SUR NAME <input type="text"/> INITIALS <input type="text"/>	<input type="text"/>
2. Details of the Insured person : .....	<input type="text"/>
(In respect of whom claim is made)	<input type="text"/>
(a) Name & relationship to the insured : .....	<input type="text"/>
(b) Present Completed Age : .....	<input type="text"/>
(c) Occupation : .....	<input type="text"/>
(d) Residential Address : .....	<input type="text"/>
3. Policy No. <input type="text"/> <input type="text"/>	<input type="text"/>
4. Details of Previous Mediclaim Policies : .....	<input type="text"/>
i) Policy No. and Policy Period : .....	<input type="text"/>
ii) Policy No. and Policy Period : .....	<input type="text"/>
iii) Policy No. and Policy Period : .....	<input type="text"/>
Note: Essential if Cost of Health Check-up is claimed.)	<input type="text"/>
5. Nature of Disease/illness contracted or injury suffered	<input type="text"/>

6. Date of injury sustained or Disease/  
Illness first detected.

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Date      Month      Year

7. (a) Name & Address of the attending  
Medical Practitioner

: .....  
: .....  
Pin Code.....  
State/U. Territory.....

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(b) Qualification & Telephone No

: .....

(c) Registration No.

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8. (a) Name & Address of the Hospital/  
Nursing Home/Clinic

: ...G C GUPTA HOSPITAL, HUDA, PANIPAT  
Pin Code ...132103.....  
State/U. Territory .....HARYANA.....

(b) Date of Admission

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Date      Month      Year

(c) Date of Discharge

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Date      Month      Year

9. If the claim is for Domiciliary  
Hospitalisation, Please indicate

: .....

(a) Date of Commencement of treatment

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(b) Date of Completion of treatment

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(c) Name & Address of attending  
Medical Practitioner

: .....  
Pin Code .....  
State/U. Territory .....

(d) Telephone

: .....

(e) Registration No

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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 the following documents (Please indicate by Û ) : ——

1. Bill Receipt and discharge Certificate/card from the Hospital.
2. Cash Memos form the Hospital/Chemist(s), supported by the proper prescription.
3. Receipt and pathological tests reports from a pathologist supported by the note from the attending Medical Practitioner/Surgeon demanding such Pathological tests.
4. Surgeon's certificate Stating nature of operation performed and Surgeon's bill and receipt.
5. Attending Doctor's/Consultant's/Specialist's Ansesthetist's bill and receipt and certificate regarding diagnosis.
6. In case of domiciliary Hospitalisation, receipt from a qualified nurse who attended the patient at his/her residence duly supported by a certificate from attending Medical Practitioner.
7. Certificate from the attending Medical Practitioner giving reasons for allowing treatment at home.
8. 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 have made or shall make any false or untrue statement, suppression or concealments, 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 admissible under any other Medical Scheme or Insurance.

Dated.....this.....day of .....2003.

Signature of the Claimant

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FOR OFFICE USE:

Date of Claim

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CATEGORY OF BENEFIT.....

SCHEDULE OF EXPENSES INCURRED BY THE CLAIMANT	TO BE FILLED IN BY THE CLAIMANT	FOR OFFICE USE ONLY			
		Amount available	Amount Payable	Amount not Payable	Balance benefit to the Credit
Details of expenses claimed under Hospitalisation Domiciliary Hospitalisation (To be supported by Bills/Receipt,Cash Memo etc.)	Amount Claimed				
1. (A) HOSPITALISATION BENEFITS:					
(a) Room, Board, Nursing Expenses for.....days.....@.....per day					
(b) I.C.unit for.....days.....@.....per day					
(B) Hospitalisation Benefits other than Room Board & Nursing Expenses & ICCU (including Pre & Post Hospitalisation)					
1. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists fees.					
2. Anaesthesia, Blood, Oxygen, Operation Theatre Changes,Surgical Appliances,Medicines & Drugs, Diagnosti,c Materials, & X-ray, Dialysis, Chemotherapy, Radiotherapy, cost of Pacemaker Artificial limbs & cost of Organs and similar other expenses					
II. DOMICILIARY HOSPITALISATION:					
1. Medical Practitioners, Consultants & Specialists fee for visits etc.					
2. Blood, Oxygen,Diagnostic materials, X-ray Employment of qualified Nurses, Medicines and Drugs and similar expenses.					
III. COST OF HEALTH CHECK-UP					
TOTAL RS.					
Date:					
Place:					

Signature of the Claimant

FOR OFFICE USE ONLY

Checked by:

Total amount payable under the claim	Rs. ....
Less: Advance on account payable, if any	Rs. ....
Net amount payable	Rs. ....

Approved by:

In case entire claim is not admissible, reasons thereof

Passed for payment of Rs. ....

COMPETENT AUTHORITY