

**MEDSAVE HEALTH CARE LTD.**  
**F-701A LADO SARAI NEW DELHI 110030**  
**CLAIM FORM**

MEDSAVE REFERENCE . NO.: \_\_\_\_\_

NAME OF THE INSURED: \_\_\_\_\_

CLAIM IN RESPECT OF: \_\_\_\_\_ RELATION \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CONTACT NO.: \_\_\_\_\_ Email Address \_\_\_\_\_

**NAME OF INSURANCE COMPANY:** \_\_\_\_\_

INDIVIDUAL      GROUP POLICY  
NAME OF CORPORATE \_\_\_\_\_  
EMPLOYEE Code No. \_\_\_\_\_

DATE OF COMMENCEMENT OF POLICY: \_\_\_\_\_

SUM INSURED + CB % \_\_\_\_\_

DIAGNOSIS \_\_\_\_\_

**DOA** \_\_\_\_\_ / **DOD** \_\_\_\_\_

HOSPITAL NAME \_\_\_\_\_ REGD NO../ NO OF BEDS \_\_\_\_\_

**DATE OF DETECTION OF ILLNESS** \_\_\_\_\_

ANY CLAIM TAKEN IN PAST \_\_\_\_\_

IF YES GIVE DETAIL \_\_\_\_\_

**TOTAL AMOUNT CLAIMED:**

ROOM RENT / NC \_\_\_\_\_

PROFESSIONAL FEES \_\_\_\_\_

OTHER CHARGES \_\_\_\_\_

TOTAL \_\_\_\_\_

**NO OF DOCUMENTS ATTACHED:** \_\_\_\_\_

NAME & ADDRESS OF TREATING DOCTOR \_\_\_\_\_

TELEPHONE NO. & ADDRESS \_\_\_\_\_

I here by warrant the truth of the foregoing particulars in every respect & authorize Medsave Healthcare Ltd to process my Hospitalization bills & 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 benefits are admissible under any other Medical scheme or Insurance .**

The issuance of this form does not amounts to admissibility of any liability under the policy  
I have no objection if my records are verified from the treating Hospital

**DATE** \_\_\_\_\_

**SIGNATURE OF CLAIMANT**