Reliance
General Insurance
Company Limited

(Registered Office: 3rd floor, Maker Chambers IV, Nariman Point, Mumbai – 400 021)

Claim form for Group Mediclaim Insurance Policy

Policy No: ______________________________Period of Insurance: _____ To ________

1. Name of the Employee & Email id.	
2. Name of the insured person (in respect of whom the claim is made)	
3. PHS I D Card No.	
4. Relationship to the employee	
5. Present completed age	
6. A) Name & address of the hospital/nursing home/clinic. B) Registration No.	

7. Schedule of expenses incurred by the claimant under hospitalisation/domiciliary hospitalisation (to be supported by bills/receipts, cash memos etc.)

	Expenses incurred during hospitalisation	Pre hospitalisation expenses (Rs)	Post hospitalisation expenses (Rs)	Total (Rs)
Hospitalisation Benefit				
Domiciliary hospitalisation				

In support of the claim, I enclose the following documents (please indicate by ✓)

1. Bill, stamped receipt and discharge certificate card from the hospital and/or surgeon in original.
2. Cash Memo from the hospital / chemists(s) in original supported by prescription.
3. Stamped receipt in original and pathological test reports from a pathologist supported by prescription.
4. Attending Doctor's / Consultant's / Specialist's / Anesthetist's bill with stamped receipt in original and certificate regarding diagnosis.
5. 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.
6. Certificate from the attending Medical practitioner giving reasons for allowing treatment at home.

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, 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 at _________________ this day of _____________ 200 .

Signature of the Claimant