Reliance Life Insurance
Anil Dhirubhai Ambani Group
A Reliance Capital Company

Reliance Wealth + Health Plan

CLAIM FORM – HOSPITAL CASH BENEFIT
(To be filled in block letters by the Claimant/Principal Insured)

Please answer all questions carefully. Also attach the copy of the health card along with identity proof.

1. Name of the Principal Insured: ____.

2. Policy no. (As on your policy schedule): ____.

   Date of commencement of the policy: _______________ Policy Term: _________________________.

   Date of Birth: _____________ Age: ____________ Gender: M / F Riders: ____________________

   Daily Hospital Cash Benefit Amount: ______________ Sum Assured: _________________________

3. Address of the Principal Insured: ____

   ____

   Telephone: ____________________________________Mobile: ______________________________

   E-Mail: ____

4. Name of the Insured person (in respect of whom the claim is made): __________________________

   Relationship with Principal insured _________________ Date of Birth/ Age last Birthday:_________

5. Date of injury sustained or disease/illness first detected: _____________________________________

6. Please describe the injury sustained or disease/illness contracted (including cause)

   ____

7. Name of the attending Medical practitioner: ____

8. Address of attending Medical practitioner: ____

   ____

   Telephone: ____________________________________Mobile: _____________________________

   E-Mail: ____ Fax _________________________________

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Qualification ______________________________ Registration no ____________________

9. Name of Hospital/ Nursing home: ____

10. Address of Hospital/ Nursing home/Clinic: ____

____

Telephone: ______________________________Mobile: _________________________

E-Mail: __________________________________ Fax ___________________________

11. Date & time of admission: ________________ Date & time of discharge: _______________

12. No of Days in Hospital (In a ward other than ICU): ______________

13. No of Days in ICU: __________ 14. Date & time of admission in the ICU: _____________

15. Date & time of discharge from ICU: ______________________

16. Date and mode of intimation given to the TPA __________________________________

17. Pre-authorization approval taken: Yes / No (Attach proof): _________________________
If No, please provide reason for the same______________________________________
____

18. Have the police authorities been informed? Yes / No _____________________________
(For accident case only)

19. Have you lodged any claim under this policy or any other health insurance policy including mediclaim, hospital case benefit etc. If yes, please provide the following details:

a. Name of insurance company: ____
b. Diagnosis: ____
c. Whether settled/repudiated: ____
d. Amount: ___________________

20. Schedule of expenses incurred under the following benefits (to be supported by original Bills / receipts, memos, discharge summary, hospital report or copies of the original reports attested by TPA authorized official etc.) Please refer to your policy schedule for coverage details. In case of insufficient space, please attach an additional sheet.

Hospital cash benefit____

ICU____

Recuperation Benefit ______________________________________

Major surgical Benefit ______________________________________

Critical illness ____

Signature of insured person: ____________________

Date: _________________

Place:_________________

In support of the above claim, I enclose following documents (Please indicate by tick mark).

1) Bill, Receipt and Discharge certificate/card from the hospital.
2) Pathological test report from a Pathologist.
3) Attending Doctor's / Surgeon's certificate supporting hospitalization (including ICU admission if any), diagnosis and treatment.

Declaration by Claimant

I have undergone treatment of the illness or bodily injury referred above as per the details given by me. I hereby warrant the truth of the foregoing particulars in every respect and I further confirm and warrant that there is no other information relevant to my right to claim which would have a bearing upon your consideration of my claim and with which you ought to be acquainted. I here by give my consent and authority for you to seek medical information (Indoor case papers, reports, documents, including photocopies thereof/pertaining my, admission/treatment) from any Hospital or Doctor from which or whom I have at any time sought or shall seek medical attention concerning any disease/ sickness, ailment or injury, which affects my physical or mental health.

Signature of claimant:
Date:

Declaration by Primary Insured: I hereby warrant the truth of the foregoing particulars in every respect of the above claim. I hereby confirm that the amount payable to me under the coverage terms and conditions would, when received constitute full and final discharge towards this claim.

Signature of the Primary Insured:
Date:

Documents check list for health plan:

Hospital Cash Benefit:

1. Hospitalization claim form duly signed by the insured person(s)/policy holder.
2. Original or copies of the original reports attested by TPA authorized official discharge card/discharge summary.
3. Original or copies of the original reports attested by TPA authorized official reports of all investigations.
4. Hospital Bill and receipts for payment.
5. Please enclose a case summary report giving history of the case.
6. Copy of FIR (in case of accident).

The above list is not exhaustive; TPA/RLIC may request additional documents / information, if any, for processing the claim.

Critical Conditions (25) Rider/Major Surgical Benefit:

1. Specialist doctors certificate confirming the diagnosis and when the symptom first occurred.
2. Relevant investigation reports (Radiology, Pathology etc) confirming the diagnosis.
3. Hospital admission & discharge card/certificate plus all documents as per 1 to 5 in respect of hospitalization as above.

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Attending Medical Practitioners Statement

To be answered by attending medical practitioner in complete.
(To be filled in case discharge summary does not contain the following information)

1. Name of the Insured Person:_______________________________ 2. Age of the Insured: _________

3. Address of the Principal Insured: ____

____

Telephone: __________________________________Mobile: ___________________________

E-Mail: _______________________________________

4. Nature of disease suffered by insured: ____

5. What treatment was given /operation performed, if any?

____

6. When did the first symptom appear: ____

7. Whether the present ailment is a complication of pre-existing disease? If yes, please give details:

____

8. Whether the treatment given necessitates admission: _______________________________________.

9. Whether the disease/disorder is Congenital in nature? ______________________________________

10. What was the history reported to you at the time of consultation? ____________________________

____

For accident case:

11. Are the injuries traceable to any pre-existing ailment/infirmities?

____

12. Was he/she under the influence of intoxicants or drugs at the time of accident?

____

13. Any medico legal case filed?

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14. Have you provided medical treatment to the insured previous to this treatment? If yes, specify the details
    ____

Signature of the Medical Practitioner _____________________ Date: ______________________

Name of attending Medical practitioner: Dr____

Address of the Medical practitioner/ Hospital/ Clinic: ___________________________________

____

E-Mail: ______________________________________ Fax ____________________________

Qualification __________________________________ Registration no __________________

Please find attached a short case history of the patient.