

Reliance Wealth + Health Plan

**CLAIM FORM – MAJOR SURGICAL BENEFIT
(To be filled in block letters by the Claimant/Principal Insured)**

S.NO	POLICY NO.	
1.	Name of the Policy holder	
1a.	Date Of Commencement of base plan	
1b.	Date of Commencement Of Major Surgical Benefit Rider	
2.	Details of the insured person: (in respect of whom claim is made)	
	Relationship with the insured	
	Present completed age	
	Gender	
	Occupation	
3.	Sum Assured	
4.	Date of Injury sustained or Disease/Illness First detected	
5.	Nature of Disease/illness contracted or injury suffered	
6.	Name of the surgical procedure performed	
7.	Name of the attending Medical Practitioner	
(a)	Address of the attending Medical Practitioner	
(b)	Telephone No	
(c)	Qualification	
(d)	Registration No	
8.	Name & Address of the hospital/Nursing Home/ clinic	
(a)	Registration Number	
(b)	No of beds in the Hospital	
(c)	Date of Admission	
(d)	Date of Discharge	
(e)	Date of Surgery	
9.	Have you lodged any claim under this policy or any other health insurance policy including Mediclaim, critical illness etc. If yes, please provide the following details a)Name of the company b)Diagnosis c)Whether settled/ repudiated d)Amount	
10	Was any benefit paid under this policy for this rider earlier	Yes/No If Yes
10 a.	Date of Payment	
10 b.	Sum Assured Paid	

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/Surgeons certificate stating nature of operation performed

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 hereby 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:

Dated

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

Dated

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?

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.