

CLAIM FORM



(Issuance of this form does not amount to admission of any liability under the claim on the part of the insurance.)

Name of the Insurance Company:

Address of the Policy issuing Office:

EMSL's ID No. :

Policy No.:

1. Name of the Insured (In whose name policy is issued):

2. Details of the insured Person (In respect of whom claim is made):

(a) Name & relationship to the insured:

(b) Present completed age:

Phone No.:

(c) Occupation:

Mobile No.:

(d) Residential address:

(e) E-Mail – I.D.

3. Bank Details of the Insured/Claimant (in whose name policy is issued): **Mandatory Details**

(a) Name of the Account holder

(b) Bank Name:

(b) Branch Name:

(c) IFSC Code:

(e) Account Number:

(f) Re-enter Account Number:

(g) Account Type (saving/current)

(h) Bank Address

(i) Copy of cancelled cheque leaf

4. Nature of Disease/illness contracted or injury suffered:

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

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

(b) Date of Admission:

(c) Date of Discharge:

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

(b) Qualification:

Telephone No.:

(c) Registration No.:

8. Have you been insured under any Mediclaim Scheme earlier:

(Whether with us or any other Insurance Co.) If yes, photo

Copies of previous year's Insurance policies must be enclosed

9. Date of Commencement of very first insurance for this insured:

Person with continuous Insurance Cover

10. If the claim is for Domiciliary Hospitalization:

Please indicate

(a) Date of Commencement of treatment:

(b) Date of Completion of treatment:

(c) Name & Address of attending Medical:
Practitioner

11. Total Amount Claimed: Rs.

