

UNITED INDIA INSURANCE CO. LTD.,
(A subsidiary of General Insurance Corporation of India)
Regd. & Head Office: United India House, 24, Whites Road, Chennai 600 014.

## **DOMICILIARY HOSPITALIZATION CLAIM FORM**

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

Please give the following information correctly and completely to enable the Company to process your claim promptly.

1		ne of the Insured (in whose name policy sued)	:			
2	Details of the Insured person (in respect of whom claim is made)					
	(a)	(a) Name & relationship to the Insured				
	(b)	Present completed age	:			
	©	Occupation	:			
	(d)	Residential address	:			
3	Poli	cy no.	:			
4	injur	ure of disease/illness contracted or ry suffered				
5	Date of injury sustained or Diseases/illness first detected			Date	Month	Year
6	(a)	Name & address of the attending Medical Practitioner	:			
	(b)	Registration no.	:			
	©	Qualification & Tel. no.	:			
7	(a)	Name & address of the Hospital/Nursing Home	:			
	(b)	Registration no.	:			
	©	Date of Admission	:	Date	Month	Year
	(d)	Date of Discharge	:	Date	Month	Year
8	If Hos	If the claim is for Domiciliary Hospitalizations, please indicate				
	(a)	(a) Date of commencement of treatment		Date	Month	Year
	(b)	Date of completion of treatment	:	Date	Month	Year
	©	Name & Address of attending Medical Practitioner	:			

	(d)	Telephone n	0.		:							
	(e)	Registration	no.		:							
I have incurred on the treatment of Disease/illness/accident referred of above, the expenses as per the given by me in the Schedule of Expenses given overleaf.  I hereby warrant the truth of foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statements, 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 20												
Signature of the Claimant  SCHEDULE OF EXPENSES INCURRED AND BEING CLAIMED BY THE CLAIMANT												
Sr No	_			Na	Nature of Expenditure				Amt. claimed ( ` )	Amt. payable ( ` )		
		No.	Date									
	-											
Discharge Card incorporating detailed Discharge Summary and Case History is mandatory to be submitted separately with the Claim Form.  Signature of the Insured Person												
W.E.F. 16/08/2011, all Health claims will be paid through ELECTRONIC TRANSFER (NEFT/RTGS), hence it is mandatory to give following details to TPA:												
1		me of the Acco	ount holde		1							
3	Bank name : : : : : : : : : : : : : : : : : : :											
3	or any special characters)											
4												
5	Account type (savings/current) :											
6	Bar	nk address		:								
7	7 Mobile number :											
8												

Attach copy of cancelled cheque leaf to ensure accuracy of details provided.