

**Reliance Critical Illness Policy
Claim Form**

Issuance of this form does not amount to admission of any liability under the Policy on the part of the Company. Please give the following information correctly and completely to enable us process your claim promptly.

To be filled in BLOCK LETTERS. Please answer all questions fully.

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

2. Address of the Insured
Plot No./Door No. _____ Building Name _____
Road/Street/Sector _____
Area _____
Taluka/Village/District/City _____ Pin Code _____
State _____ Country _____
Telephone _____ Mobile _____
E-mail _____

3. Name of the Insured Person (in respect of whom the claim is made)

Relationship with the Insured _____
Present completed age _____ Occupation _____

4. Policy No. (in full) _____ Sum Insured _____
Period of Insurance [d, d | m, m | y, y, y, y] to [d, d | m, m | y, y, y, y]

5. Nature of disease/illness contracted, injury sustained or surgery performed?

6. Is the disease/illness contracted or surgery performed due to any accident? Yes No
If YES, please provide the details of accident _____

7. Date on which you first visited a doctor with complaints related to this illness/injury. [d, d | m, m | y, y, y, y]

8. Name and Address of the attending Medical Practitioner
Dr. _____
Plot No./Door No. _____ Building Name _____
Road/Street/Sector _____
Area _____
Taluka/Village/District/City _____ Pin Code _____
State _____ Country _____
Telephone _____ Mobile _____
E-mail _____ Fax _____
Qualification _____
Registration no. _____



9. Please give details of the treatment you have received including dates of out patient or inpatient treatment

10. Have any of your blood relatives suffered from similar or related illness? Yes No

If YES, give details of when it was initially diagnosed _____

11. Have you been hospitalized? Yes No

If Yes, Name & Address of Hospital/Nursing Home

Plot No./Door No. _____ Building Name _____

Road/Street/Sector _____

Area _____

Taluka/Village/District/City _____ Pin Code _____

State _____ Country _____

Telephone _____ Mobile _____

E-mail _____ Fax _____

12. Date of admission Date of discharge

13. Is this the first claim under this Policy? Yes No

If NO, please quote previous claim number and details _____

14. Total amount claimed (Rs) _____

In support of the above claim, I enclose the following original documents (Please indicate)

- Duly completed Claim Form
- Certificate from treating Medical Specialist confirming the diagnosis of the named illness or performance of surgery.
- Details of first symptoms and date of occurrence of the disease/illness/injury/surgery along with complete medical history of the Insured/Insured Person.
- Confirmation that the Insured Event does not relate to
 - i) any pre-existing illness
 - ii) any disease/illness/injury which existed within the first 3 months of commencement of period of Insurance.
- In case of Hospitalisation, please provide hospital discharge card/clinical notes etc.
- FIR copy or medico legal certificate (for Illness resulting from Accident).
- Any other relevant documents.

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.

I also consent & authorize the Company to seek medical information from any Hospital/Medical Practitioner who has at any time attended on me. I hereby authorize any hospital, physician, or other person who has treated attended or examined me, to furnish to the Company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment of Insured/ Insured Person including copies of relevant hospital or medical records. A Photostat copy of this authorization shall be considered as effective and valid as the original.

Dated at _____ this _____ day of _____ 20__

Signature of the Claimant