



युनाइटेड इंडिया इन्श्योरेन्स कं. लि.

(भारत सरकार का एक उपक्रम)

UNITED INDIA INSURANCE CO. LTD.

(A Govt. of India Undertaking)

Issuing Office	
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HOSPITALISATION BENEFIT POLICY

CLAIM FORM

CLAIM NO.

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

Please give the following information correctly and completely to enable the Company to process your claim promptly, if the claim is under Personal Accident Insurance, please complete a Personal Accident Claim Form.

TPA ID No. :

1. Name of the Insured

(in whose name policy is issued)

SURNAME

INITIALS

FOR OFFICE
USE ONLY

PFM NO.

2. Details of the Insured Person
(in respect of whom claim is made)

(a) Name & relationship to the
Insured :

(b) Present completed Age :

(c) Occupation :

(d) Residential Address :

3. Policy No. :

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

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

Date

Month

Year

6. (a) Name & Address of the
attending Medical Practitioner :

Pin Code _____

State/U. Territory _____

(b) Qualification & Telephone No. :

(c) Registration No. :

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

Pin Code _____

State/U. Territory _____

(b) Date of Admission :

Date

Month

Year

(c) Date of Discharge :

Date

Month

Year

Regd & Head Office : UNITED INDIA HOUSE, 24, Whites Road, Chennai-600 014
Regional Office Kolkata : Himalaya House (2nd Floor), 38B, Jawaharlal Nehru Road, Kolkata- 700 071

Contd. ...

I have incurred on the treatment of Disease/illness/Accident referred of above, the expenses as per the details given by me in Schedule of Expenses given overleaf.

In support of the above claim, I enclose the following documents (please indicate by) :

1. Bill, Receipt and Discharge certificate card and from the Hospital.
2. Cash Memos from the Hospital Chemist(s) supported by the proper prescription.
3. Receipt and Pathological test reports from a pathologist supported by the note from the attending Medical Practitioner Surgeon demanding such pathological tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's bill and receipt.
5. Attending Doctor's / Consultants/Specialist's/Anaesthetist's bill and receipt and certificate regarding diagnosis .
6. In case of Domiciliary Hospitalisation, receipt from a qualified nurse who attended the patient at his/her residence duly supported by a certificate from attending Medical Practitioner.
7. Certificate from the attending Medical Practitioner giving reasons for allowing treatment at home.
8. Certificate from the attending medical Practitioner/Surgeon that the Patient is fully cured.

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.

Dated at this day of 200

Signature of the Claimant

FOR OFFICE USE ONLY

Date of Claim

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Date

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Month

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Year

1. Name of the insured (Staff) :

2. EMP No / PFM No :

3. Name of the Bank : UCO Bank

4. Name and address of the branch :

5. Account No (14digit) :

6. Type of account : SB / OD /CC

7. MICR Code No : 8. IFSC No :