



Universal Sampo General Insurance Co. Ltd.

(A joint venture between Allahabad Bank, Sampo Japan Insurance Inc., Indian Overseas Bank, Karnataka Bank and Dabur Investments.)

Regd. Office: 201-208, Crystal Plaza, Opp. Infiniti Mall, Link Road, Andheri (West), Mumbai - 400 058.

HEALTH INSURANCE CLAIM FORM

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

- a) Claim form is to be filled in capital letter & signed by the insured/beneficiary.
- b) Please do not leave any column unanswered.
- c) Please read carefully the attached list of documents required to speed up processing of your claim.
- d) If there is insufficient space, kindly use a separate sheet which can be attached to this form.

Claim No.

A. DETAILS OF INSURED

Name of the Insured (in whose name policy is issued)	First Name	Middle Name	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name of the Insured person (In respect whom claim is made)	First Name	Middle Name	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Relationship with Insured	<input type="text"/>		
Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Email ID <input type="text"/>	
Communication	<input type="text"/>		
Address	<input type="text"/>		
City/Taluka	District	State	
Pin Code	STD code	Phone No.	Mobile No.

B. DETAILS OF POLICY

Policy No. <input type="text"/>	/ <input type="text"/>	/ <input type="text"/>	/ <input type="text"/>	Health card No. <input type="text"/>
Period of insurance	from <input type="text"/>	to <input type="text"/>	Sum Insured	<input type="text"/>

C. DETAILS OF OTHER POLICIES

Have you been insured under any Medclaim scheme of any other insurance companies? If "Yes", please enclose photocopies of all previous policies.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of commencement of very first insurance for the Beneficiary with continuous insurance coverage?	from <input type="text"/> to <input type="text"/>

D. DETAILS OF PREVIOUS CLAIM

Have you incurred any claim of the same beneficiary earlier? If so give details.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous claim no. <input type="text"/>	
Diagnosis <input type="text"/>	
Date of admission <input type="text"/>	Date of Discharge <input type="text"/>
Repudiated <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, reason for Repudiation <input type="text"/>

E. DETAILS OF INCIDENCE

Nature of disease, illness, injury	<input type="text"/>		
Symptoms & Signs	<input type="text"/>		
Date of incidence <input type="text"/>	Date of admission <input type="text"/>	Time of admission <input type="text"/> : <input type="text"/>	AM/PM.
Date of discharge <input type="text"/>	Time of discharge <input type="text"/> : <input type="text"/>	AM/PM.	
Type of admission <input type="checkbox"/> Emergency	<input type="checkbox"/> Planned	<input type="checkbox"/> Day Care	<input type="checkbox"/> Domiciliary

F. DETAILS OF HOSPITAL

Name of the Hospital

Address

City/Taluka District State

Pin Code STD code Phone No. Mobile No.

G. DETAILS OF CURRENT CLAIM BILLS

	Expense Details	Amount (Rs.)
(A)	Pre-hospitalization expenses	
(B)	Hospitalization expenses	
(C)	Post-hospitalization expenses	
(D)	Day care hospitalization	
(E)	Daily hospital cash allowance	
(F)	Maternity expenses	
(G)	Domiciliary expenses	
TOTAL AMOUNT CLAIMED		

Description	Bill Date	Bill No.	Bill Amount (Rs.)	Claimed Amount (Rs.)
Room rent				
Investigations				
Medicines				
Surgeon fees				
Anesthetist fees				
Operation theatre fees				
Consumables				
Consultation fees				
Ambulance expenses				
Other charges 1				
Other charges 2				
GRAND TOTAL				

H. ENCLOSURES

Claim form duly signed
 Pre-authorization form
 Discharge summary
 Hospitalization bills
 Medicine bills
 Investigation bills
 Surgery/consultation fees
 Pre-hospitalization bills
 Post-hospitalization bills
 Doctor's prescription
 Medical certificate
 FIR/ MLC copy
 Investigation reports
 Any other documents
 If "Yes", please specify _____

I. INSURED'S DECLARATION

I hereby warrant the truth of foregoing statement and sincerely declare that I have not suppressed or concealed any information that is material to this claim. I understand that false declaration/s may result in USGI being able to refuse to pay the claim.

I authorize any hospital, physician or any other medical provider who has attended me or examined me to furnish USGIC such details of my medical history/treatment as they may require.

Date: Signature of Insured:

Place: Name of the Insured:

J. ATTENDING MEDICAL PRACTITIONER'S DECLARATION

I hereby certify that [] was treated by me on [] for [] which first incurred on []

The ailment was caused by /in any way associated with the below mentioned conditions;

Pregnancy or childbirth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sterility	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cosmetic or aesthetics treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Correction of eye sight	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital deformities or anomalies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Intentional self injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Use of Intoxicating drugs and alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV,AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal disease or sexually Transmitted disease	<input type="checkbox"/> Yes <input type="checkbox"/> No

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Name of the treating Medical Practitioner: First Name [], Middle Name [], Last Name []
 Registration No. [] Qualification []

Date: [] Stamp and Signature of the Medical practitioner []
 Place: []

***Applicable only for General Health Check up Claims**

K. DETAILS OF GENERAL HEALTH CHECK-UP

Name of the Hospital []
 Address []
 City/Taluka [] District []
 State [] Pin Code []
 STD code [] Phone No. [] Email ID []
 Claim type Cashless Reimbursement

Description of tests carried out CBC, X-ray etc. []

Date of check up [] Amount claimed (Rs.) []

I confirm that no claim has been made by my family members or me during the past four continuous policy periods nor any claim is proposed to be lodged for the same period.

Date: [] Signature of Claimant: []
 Place: [] Name of the Claimant: []

L. DETAILS OF OTHER INFORMATION

Do you wish to provide any other information? Yes No

If "Yes", specify _____

I/We, the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect; and I/we agree that if I/We have made, or in any further declaration, the Company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited, and the Policy shall be null and void, and all rights to recover thereunder in respect of past or future loss/accidents shall be forfeited.

Date: [] Signature: []
 Place: [] Name of Insured: []