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)
   (a) Bank Name: (b) Branch Name:
   (c) IFSC Code: (e) Account Number:
   (f) Re-enter Account Number:

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.

I have incurred on the treatment of disease/illness/accident referred to above the expenses as per the details given by me in the Schedule of Expenses given overleaf.

In support of the above claim, I enclose the following documents:

Claim Form Duly Signed:	Yes/No	Pre Hospitalization bills ___ Nos.	Yes/No
EMSL Pre-Authorization Certificate:	Yes /No	Post Hospitalization bills ___ Nos.	Yes/No
Claim Intimation Letter	Yes/No	Hospital Payment receipt	Yes/No
Discharge Summary	Yes/No	Hospitalization Bill	Yes/No
Medicines Bills with Dr's prescription	Yes/No	Surgeon's surgery certificate	Yes/No
Operation Theater / Pharmacy Bills	Yes/No	Surgeon/Consultant's bills	Yes/No
Investigation reports with Dr's prescription	Yes/No		
MRI ___ Nos.	Yes/No	ECG ___Nos.	Yes/No
CT scan ___ Nos.	Yes/No	X-Ray ___Nos.	Yes/No
US scan ___ Nos.	Yes/No	Other's (If any)	Yes/No

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: Signature of the Claimant

Schedule of Expenses Incurred

Sr. No.	Date of the Bill	Bill No	Name of the Hospital/Lab/Medical Shop	Amount
			Total	

Consent Form

From:
Patient's Name and address:

To:
Whomsoever it may concern: (hospital/doctor)

Sirs,

I here by authorize **E-Meditek (TPA) Services Limited** representatives free and unlimited access to seek medical information (Indoor case papers, reports, documents, including photocopies thereof / pertaining my, admission / treatment) from any hospital / medical practitioner from which or whom I have at any time sought or shall seek medical attention concerning any disease/ sickness, ailment or injury, which affects my physical or mental health.

Yours faithfully,

Signature of the Patient