# **Hospital Cash/Medical Expenses**

## **Claim Form**



#### IMPORTANT:

- Issuance of this form is not an admission of Liability or a waiver of the terms, conditions and exceptions of the insurance contract.
  If the space provided is insufficient, please attach additional sheets.

Policy No.				Claim No.	
1. DETAILS OF INSURE	<b>E</b> D				
Name		<del></del>			
Address		First Name	N	Aiddle Name	Surname
Address					
	City				
	State			PIN	
	Phone (O)			(R)	
				Mobile	
	Name of the contact person				
	Designation				
	Tel			Fax	
	E-mail				
2. DETAILS OF SICKNE	22				
Time and Date		D D M M Y Y Y	Y		
Diagnosis					
Place and Location Address					
71441000	City				
	City			DIN	
	State			PIN	
2 TREATMENT RETAIL	C				
3. TREATMENT DETAILS					
Name of the Attending I	Doctor	<del></del>	-		
	Tel			Fax	
	Date(s) of Consult	tation D D M M Y	YYY		
Name of the Hospital(s)	<del></del>				
(If hospitalized)					
Address					
	City				
	State			PIN	
	Tel			Fax	
	E-mail ID				
	Period of hospital	lization: From D	M M Y Y	Y Y to D D M M Y	YYY
	Diagnosis/Surger	у			

## 4. AMOUNT OF EXPENSES Please attach a separate sheet if the space is insufficient. a) In hospital cash (If covered). **From** То **Amount** Have the Police Authorities been informed of this accident? Yes No I hereby declare that I have suffered injuries as described above and all the details given are ABSOLUTELY TRUE AND CORRECT. I hereby agree to forfeit all my rights to compensation if any of the foregoing facts and/or details are found to be false or incorrect. I further authorise the hospital, doctor diagnostic laboratory, organisation, establishment or any other body or person dealt with in the course of this claim to give any information or document sought for by the Insurance Company. Date: \_ Place: \_ Signature of the Insured ATTENDING PHYSICIAN'S STATEMENT PLEASE ANSWER ALL QUESTIONS Name & Age of Injured Person: Address City State PIN Phone (O) (R) Mobile Fax Details of the Sickness: Was the injured person suffering from any disease : \_\_\_ Was the Claimant hospitalized? If so for what period? \_ What treatment was given and Operations performed? \_\_\_\_ Give all dates of treatment : \_ Home: From\_ \_ To \_\_ \_\_ Clinic/Hospital: Form \_\_ \_ To \_ Are you his usual medical Attendant? If you have treated him for any previous illness, Please give details. Have other Doctors been in Attendance or Consultation? If yes, Please give details. What is the Prognosis? \_

## Tata AIG General Insurance Company Limited

PIN

(R) Mobile

Date

Regn No.

Doctor's Signature

Address

Doctors Name & Seal:

City

State Phone (O)

Fax

Registered office: Peninsula Business Park, Tower A, 15th Floor, G. K. Marg, Off Senapati Bapat Road, Lower Parel, Mumbai - 400 013.