



Oriental insurance

PRITHVI, AGNI, JAL, AKASH SAB KI SURAKSHA HAMARE PAAS

CLAIM FORM FOR NIRAMAYA HEALTH INSURANCE SCHEME

Notes: This form is issued without admission of liability and must be completed and returned to the insurance company for processing the claim.

Claim No (to be allotted by the insurer): _____ Policy No: _____

1. Details of the Claimant:

Name in Full: _____

Present Age: _____ Years, Relationship with the patient _____

Telephone No.: _____

Residential Address: _____

2. Details of the Patient:

Name in Full: _____ Age: _____ Years, Disability: _____

Son/Daughter of: _____ BPL Card No. _____

Residential Address: _____

3. Permanent Business or Occupation: (If more than one state all)

4. (a) Name & address of the hospital where the treatment was conducted:

(b) Name, address & who conducted the treatment

5. Nature of claim : OPD/ IPD/ Therapy

a) Date/s: _____

b) Details of disease: _____

c) Date of Admission: _____ Time: _____

d) Date of Discharge: _____ Time: _____

6. Total Claimed Amount : _____

7. 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 : _____

d) Qualification : _____

e) Telephone No. : _____

8. Are you insured elsewhere? If so, give details:

- a) Name of the Company and Sum Insured: _____
- b) The amount you are entitled to Claim under above policy: _____

In support of the above claim, I enclose following documents {Please indicate by (☐)}

1. Bills, Receipt and Discharge Certificate/card from the Hospital/Nursing Home.(In original)
2. CashmemosfromtheHospital/Chemist(s),supportedbytheproperprescription.(Inoriginal)
3. Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner/ Surgeon demanding such Pathological tests.(In Original)
4. Surgeons certificate stating nature of operation performed and surgeon's bill and receipt. (In Original)
5. Attending Doctor's/Consultant's/Specialist's/Anesthetist's bill and receipt and certificate regarding diagnosis, whichever is prescribed & thereby expenses incurred (In Original)
6. If any transportation bill then pls. submit the bill. (In original)

Declaration:

I HEREBY DECLARE that the particulars are true to best of my knowledge and warrant the truth of the foregoing particulars in every respect, and I agree that if I have made, or if shall make any false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited.

Place: _____

Date: _____

Signature of Insured _____

MANDATORY

Part - C-NEFT (For Direct Fund Transfer/ Electronic Fund Transfer)

As per IRDA Circular No.: IRDA/F&A/CIR/GLD/056/02/2014, Proposer's/ policy holder's bank account details are mandatory to process the claim through EFT, please provide the below details (all fields are compulsory) and provide a cancelled cheque of the proposer/ policy holder (should be of the bank account number mentioned below)

- Proposer/ policy holder name* (as per bank records) _____
- Proposer/ policy holder account no.: _____
- Name of the bank: _____
- Branch name: _____
- Address of the bank: _____
- IFSC code no. of the bank: _____ (should be same as per the provided cheque leaflet)
- PAN card no. of Proposer/ policy holder: _____ (Permanent Account Number)

Please provide an Original Blank Cancelled Cheque signed by the Proposer/ policy holder, which is mandatory for processing the claim.

Account holder's Signature

Note: Claim Form under Niramaya All Claims for settlement under Niramaya has to be submitted in the prescribed Claim Form along with relevant vouchers/bills, etc. with 30 days of treatment or discharge from hospital.

Mailing Address : **RAKSHA TPA Pvt. Ltd. J&Co Chambers, Manimala Road, Near Ganapathy Temple, Edappally, Cochin-682024. Ph: 0484 4000506**

