UNITED INDIA INSURANCE COMPANY LIMITED

Reg. & Head Office: 24, Whites Road, Chennai - 14.

BRANCH / DIVISIONAL OFFICE.....

SUPER TOP UP MEDICARE CLAIM FORM

Claim No. Policy No.

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

Please give the following information correctly and completely to enable the Company to process your claim promptly.

1	a) Name of the Insured (Name in full) b) Address c) Occupation	
2	Details of Insured Person: a) Name of the person in respect of whom the claim is made. b) Relationship to the Insured c) Present completed age d) Occupation e) Residential address.	
3	**Details of Hospitalisation**: a) Name of the Insured person (in respect of whom claim is made) b) Present completed age c) Nature of Disease / Illness contracted or injury sustained d) Date of injury sustained or disease/ illness first detected e) Date of Intimation to TPA f) Name and address of the Hospital / Nursing Home g) Date of Admission h) Date of Discharge	a) b) c) d) e) f) g) h)

5 *Details of previous hospitalisations in respect of the Insured Person/s during this policy period*

Name of the Insured person	Health Insurance Policy No./Reimbursement Benefit Scheme	Illness suffered	Date of admission	Date of discharge	Amount claimed (only Inpatient hospitalisation exp) not to include pre and post-hosp. Exp.	Amount reimbursed/ reimbursable by TPA / Reimbursement Provider**	Name of the TPA / Re.Provider

** Supporting documents in original or attested photocopies to be furnished

6	Total Expenses incurred for claimed hospitalisation	
	SCHEDULE OF HOSPITALISATION EXPENSES INCURRED	
Details of expenses claimed for Hospitalisation (to be supported by Bills, Receipts, Cash Memos along with discharge summary)		Amount Claimed Rs
a)	Hospitalisation: a) Room Board, Nursing Expenses for days @Rs. per day b) I.C.U charges for days @ Rs. per day	
b)	Non-Surgical & Surgical: a) Surgeon & Anaesthetist fees b) Medical Practitioners, Consultants and specialists fees for consultations No of visits c) Nursing expenses	
c)	a) Anaesthetic, Blood, Oxygen, Operation Theatre Charges, Surgical appliances. b) Diagnostic materials and X-Ray.,etc., c) Dialysis, Chemotherapy, Radiotherapy, Cost of peacemaker, Artificial Limbs & Cost of organs and similar expenses d) Medicines and Drugs i) Supplied by Hospital ii) Purchased from Chemists	
e)	Total Expenses	
f)	Expenses reimbursed/reimbursable under other Health Insurance Policies/Reimbursement Scheme towards all hospitalisations during the policy period plus any previous claims made under this Policy or Threshold Level whichever is higher	
g)	Claim under this Policy (e-f)	

Note : If the original bills are submitted to Primary Health Insurer/Reimbursement Provider, attested photo-copies may be furnished.

I hereby declare that I have incurred on the treatment of Disease/Illness /Accident referred above, the expenses as per the details given by me. In support of this claim, I enclose all relevant bills vouchers and other documents.
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 and I shall rendered myself liable to any legal action.

Place:
Date: Signature of Insured Person