



# CHOLAMANDALAM GENERAL INSURANCE CO. LTD.

## Claim Form

(The issue of this form is not to be taken as an Admission of Liability)

Please give the following information correctly and completely

Plan Type \_\_\_\_\_ Policy No \_\_\_\_\_ Policy Validity \_\_\_\_\_ to \_\_\_\_\_  
 PHS ID \_\_\_\_\_ Sum Insured \_\_\_\_\_

<b>1]</b>		<b>Name of the Insured / Proposer</b>	
<b>2]</b>		<b>Details of the Insured in respect of whom the claim is made</b>	
	a)	Name	
	b)	Age	
	c)	Sex	
	d)	Marital Status	
	e)	Occupation	
	f)	Residential Address	
	g)	Telephone No	
	h)	E-mail	
	i)	Name of the Employee(in case of corporate group)	
	j)	Relation with the Employee(in case of corporate group)	
	k)	Have you previously consulted the present doctor or any other doctor or hospital for the medical condition for which you are now claiming :	
<b>3]</b>		<b>Details to be filled in by Treating Physician</b>	
	a)	Nature of disease / illness contracted or injury suffered/Diagnosis	
	b)	Date of injury sustained or disease / illness first detected	
	c)	Please give a brief history of this or any related condition, with dates on which any previous consultations or treatment took place	
	d)	Name/Address/Tel.no of the provider	
	e)	Registration no. of the provider	
	g)	Registration no. of the doctor ( <b>RUBBER Stamp of the Doctor/Hospital</b> )	
	h)	Date of admission	
	i)	Date of discharge	

4] Please mark as (✓) specifying nature of claim as follows:

a) Pre-hospitalisation  Hospitalisation  Post-Hospitalisation  Hospital daily allowance

b) Type of Provider Hospital:

Network  Non-network

c) Type of Admission:

\*Emergency  Planned  Day care

\*In case of Emergency hospitalisation to non-network hospital, please enclose Doctor's letter stating the same with reasons

d) You had obtained pre-authorisation for Hospitalisation :

Yes  No

**Policy categorisation for Class of admission [Tick As (✓) a class in which your were Admitted]**

<b>Class A</b> ::	Air-conditioned Single room upwards (i.e. Suite, apartment)	
<b>Class B</b> ::	Air-conditioned or non air-conditioned single room	
<b>Class C</b> ::	Air-conditioned or non air-conditioned two-bed room	

Class D ::	More than three-bed room	
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### Please enclose separate undertaking from provider stating your class of admission and explicitly specifying whether AC / Non AC and accommodation type namely suite/apartment/single room/two bed room/more than three-bed room etc.)

	Expense Details	
a)	Pre-Hospitalisation Expenses	
b)	Hospitalisation Expenses	
c)	Post-Hospitalisation Expenses	
d)	Ambulance charges	
e)	<b>Total Amount Claimed</b>	

For Health Check Up, please specify type of check up:  
(This facility is subject to pre-authorization at PHS network providers only)

General Health Check up  Eye Check up

Name of Network provider	
Address and Contact no of Network provider	
Description of tests carried out for e.g. CBC/Sugar etc.	
Date of check up	
Amount Claimed	

**In support of the above claim following documents to be submitted otherwise it will delay the claim settlement. Please mark it (✓) which ever documents you are submitting :-**

1. Bills, Receipt and Discharge Card/Summary of procedure in case of Daycare treatment from the Hospital/Nursing Home.
2. Cash memos from the Hospital / Chemist(s), supported by the proper prescription.
3. Receipt and Diagnostic test reports from a Diagnostic centre supported by the note from the attending Medical Practitioner / Surgeon demanding such Diagnostic tests.
4. Surgeons certificate stating nature of operation performed and surgeon's bill and receipt.
5. Attending Doctor's / Consultant's / Specialist's / Anesthetist's bill and receipt and certificate regarding diagnosis, whichever is prescribed & thereby expenses incurred
6. Undertaking from provider for class of admission.

### Declaration

I/We hereby to the best of my/our knowledge and belief, warrant the truth of the above details in every respect. I/We agree that if we have made already or if I/We make in any of my/our further statements in respect of the said incident or any false or fraudulent declarations or suppress or conceal any material fact, the Policy shall be void and all rights of compensation in respect the present or future claim shall be forfeited. I hereby give my consent and authority for you to seek medical information from any Hospital or Doctor who has at any time attended me whether in relation to the subject matter of this claim or otherwise. I also hereby confirm that the amount payable to me under the coverage terms and conditions would, when received constitute full and final discharge towards my claim.

**Signature of the claimant :** \_\_\_\_\_

**Date :** \_\_\_\_\_

**Place :** \_\_\_\_\_