Royal Sundaram

HEALTH SHIELD CLAIM FORM

FOR OFFICE USE ONLY	
Issuing office	:
Date of Issue	:
Claim No	:

ROYAL SUNDARAM ALLIANCE INSURANCE COMPANY LIMITED

46, Whites Road, Chennai-600 014. Telephone : 044-28517387 - 7391 Fax: 044-2851 5500

E-mail : customer.services@royalsundaram.in

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

Please ensure that all questions are answered in capital letters

Policy Number		Certificate Number	
Name of the Bank/ Corporate partner		Membership Number	

If you have any other policy of Royal Sundaram ☐ Yes ☐ No

If yes Policy No

1. INSURANCE DETAILS

Name of the Insured	
Occupation of the Insured & Designation	
Name of the patient	
Date of Birth of patient	
Occupation of the patient	
Designation & Office Address:	
Address for Correspondence (with Pin Code)	
Help us to serve you better by providing your Tel. No./Mobile No.	STD Code :
E-mail id	

2. DETAILS OF THE INJURY / ILLNESS

Date of the injury / illness	(DD/MM/YY)
Nature of injury / illness	

In the event of injury, please give full details as to the circumstances of the accident	

3. HOSPITAL DETAILS

Details of the Hospital/Nursing Home

Name of the Hospital/Nursing Home	
Address & Telephone	
Date of Admission	DD/MM/YY
Date of Discharge	DD/MM/YY

Amount Claimed

Hospitalisation expenses	Rs.
Pre Hospitalisation expenses	Rs.
Post Hospitalisation expenses	Rs.
Total	Rs.

4. OTHER INSURANCE DETAILS

Is the patient covered under any other health insurance scheme or mediclaim ? Yes ☐ No. ☐

If 'Yes', Please give full details below

Company Name	Policy Number	Period of Insurance	Individual Sum Insured

5. PAST CLAIMS HISTORY

Company Name	Policy Number	Period of Insurance	Claim reference	Nature of illness/injury

6. DECLARATION

I hereby warrant the truth of the above particulars in every respect. I agree that if I have made, or will make any false statement, suppression or concealment, my right to claim under the policy shall be forfeited.

I consent and authorise Royal Sundaram to seek medical information from any Hospital and / or Medical practitioner who has at any time attended on the insured person.

Date DD/MM/YY

Place

Signature or thumb impression of the Insured

PLEASE CHECK THAT ALL QUESTIONS HAVE BEEN COMPLETED IN FULL AND THE FORM SIGNED AND DATED.

Please enclose :

- ☐ Test reports and prescriptions relating to First / Previous consultations for the same or related illness
- ☐ Case history / Admission-discharge summary describing the nature of the complaints and its duration, treatment given, advice on discharge etc issued by the Hospital
- ☐ Hospital Receipts / bills / cash memos in Original (Copies of charge slips if payment is made by credit card)
- ☐ All test reports for X-rays, ECG, Scan, MRI, Pathology etc.,
- ☐ Doctor's prescriptions with cash bills for medicines purchase outside
- ☐ F.I.R. in the case of accidental injury and English translation of the same, if in any other language.
- ☐ For maternity claims, ante-natal prescription mentioning LMP, EDD & Gravida.
- ☐ For all gynec related claims, Marital Status, No. of living children, LMP

TO BE FILLED IN BY THE ATTENDING PHYSICIAN
MEDICAL CERTIFICATE FORMING PART OF HEALTH SHIELD CLAIM FORM

1. Name and address of the patient

2. Age of the patient

3. Name and address of the Surgeon / Physician

4. When did the patient start suffering with the complaint ? **(DD/MM/YY)**

5. Date of first consultation (prior to hospitalisation) **(DD/MM/YY)**

6. Date and Time of admission **(DD/MM/YY)**

7. Date and Time of discharge **(DD/MM/YY)**

8. Why was the patient admitted ? (specify complaint)

9. Diagnosis

10. Please give previous medical history of the patient

11. Is the present ailment a complication of a pre-existing disease or condition ?
If 'Yes', please give details with duration of pre-existing disease.

12. Is the present ailment directly attributable to the influence of alcohol or drugs ?
If 'Yes', please give details.

13. Is the present ailment congenital in nature ?
If 'Yes', please give details.

14. Nature of surgery or treatment given for present ailment

15. For maternity claims,
LMP
EDD
Gravida
Number of living children

16. Is the Hospital / Nursing Home registered ?
If 'Yes', please give registration number.

17. How many inpatient beds does the Hospital have (including ICU) ?

18. Does the hospital have a fully equipped operation theater and qualified nurses and doctors round the clock ?

19. Any other remarks you wish to make.

Doctor's name

Qualification

Registration No.

Seal

Signature of Doctor

Date

DD/MM/YY

AME13

HS/CF/PT60338/OCT06