Royal Sundaram

HOSPITAL CASH CLAIM FORM

ROYAL SUNDARAM ALLIANCE INSURANCE COMPANY LIMITED

"Sundaram Towers" 45 & 46, Whites Road, Chennai-600 014. Telephone : 044-2851 7387 - 90 Fax : 044-2851 7376

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

Please complete the form in all respects and return the same with copy of admission / discharge summary or case history issued by the hospital and all investigation Reports.

Policy Number		Claim Number	
Certificate Number			
Name of the Insured			
Name of the Insured Person (for whom the claim is made)			
Date of Birth of the Insured Person (for whom the claim is made)			
Address for Correspondence (with Pin Code)			
Telephone Office / Residence / Mobile (Mobile number will help speedy processing of your claim)			
E-mail address			
Do you have any other Policy with us or any other insurance company, if yes, please provide details			
Date of injury / illness			
Nature of injury / illness			
In the event of injury, please give full details of accident			
Name of the hospital			
Address of the hospital with phone number			
Date & Time of Admission	Date	Time	
Date & Time of discharge	Date	Time	
Amount Claimed	Rs.		

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 Alliance Insurance Company Limited to seek medical information from any Hospital / Medical practitioner who has at any time attended on the insured person. I also agree to provide any further documents in support of the claim if sought by the Company.

Date

Place

Signature or thumb impression of the Insured

MEDICAL CERTIFICATE TO BE FILLED IN BY THE ATTENDING PHYSICIAN

1. Name and address of the patient

2. Age of the patient

3. Name and address of the Surgeon(s) / Physician

4. Date and time of admission — Date | Time

5. Date and time of discharge — Date | Time

6. Diagnosis

7. Date of first consultation (prior to hospitalisation)

8. a) With what complaints was the patient admitted for?

   b) Since when was the patient suffering from the said complaints?

9. Please give previous medical history of the patient

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

11. Is the present ailment attributable to the influence of alcohol or intoxicating drugs ?

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

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

    b) How many inpatient beds does the hospital have (including ICU) ?

    c) Does the hospital have a fully equipped operation theatre, qualified nurses and doctors round the clock ?

14. Any other remarks you wish to make.

Doctor's Name

Address & Seal

Signature of Doctor

Date