

Reliance Critical Illness Policy Claim Form

Issuance of this form does not amount to admission of any liability under the policy on the part of the Company.
Please give the following information correctly and completely to enable us process your claim promptly.

To be filled in BLOCK LETTERS. Please answer all questions fully.

1. Name of the Insured (In whose name the policy is issued) _____

2. Address of the Insured
 Plot No./Door No. _____ Building Name _____
 Road/Street/Sector _____
 Area _____
 Taluka/Village/District/City _____ Pin Code _____
 State _____ Country _____
 Telephone _____ Mobile _____
Aadhaar (UIDAI) No. _____ **PAN No.** _____
 E-mail _____

Profession/Occupation Business Profession Salary Agricultural Income Savings Others
 Monthly Income Upto ₹ 20,000 ₹ 20,001 to ₹ 50,000 ₹ 50,001 to ₹ 1,00,000 ₹ 1,00,000 and above

3. Name of the Insured Person (in respect of whom the claim is made) _____
 Relationship with the Insured _____
 Present completed age _____ Occupation _____

4. Policy No. (in full) _____ Sum Insured _____
 Period of Insurance | d | d | m | m | y | y | y | y | to | d | d | m | m | y | y | y | y |

5. Nature of disease/illness contracted, injury sustained or surgery performed? _____

6. Is the disease/illness contracted or surgery performed due to any accident? Yes No
 if YES, please provide the details of accident _____

7. Date on which you first visited a doctor with complaints related to this illness/injury. | d | d | m | m | y | y | y | y |

8. Name and Address of the attending Medical Practitioner
 Dr. _____
 Plot No./ Door No. _____ Building Name _____
 Road/ Street/Sector _____
 Area _____
 Taluka/Village/District/City _____ Pin Code _____
 State _____ Country _____
 Telephone _____ Mobile _____
 E-mail _____ Fax _____
 Qualification _____
 Registration no. _____

9. Please give details of the treatment you have received including dates of out patient or inpatient treatment _____

10. Have any of your blood relatives suffered from similar or related illness? Yes No
If YES, give details of when it was initially diagnosed _____

11. Have you been hospitalized? Yes No
If Yes, Name & Address of Hospital/Nursing Home _____

Plot No./Door No. _____ Building Name _____

Road/Street/Sector _____

Area _____

Taluka/Village/District/City _____ Pin Code _____

State _____ Country _____

Telephone _____ Mobile _____

E-mail _____ Fax _____

12. Date of admission Date of discharge

13. Is this the first claim under this Policy? Yes No
If NO, please quote previous claim number and details _____

14. Total amount claimed (₹) _____

In support of the above claim, I enclose the following original documents (Please indicate)

- ▶ Duly completed Claim Form
- ▶ Certificate from treating Medical Specialist confirming the diagnosis of the named illness or performance of surgery.
- ▶ Details of first symptoms and date of occurrence of the disease/illness/injury/surgery along with complete medical history of the Insured/Insured Person.
- ▶ Confirmation that the Insured Event does not relate to
 - i) any pre-existing illness
 - ii) any disease/illness/injury which existed within the first 3 months of commencement of period of Insurance.
- ▶ In case of Hospitalisation, please provide hospital discharge card/clinical notes etc.
- ▶ FIR copy or medico legal certificate (for Illness resulting from Accident).
- ▶ Any other relevant documents.

Policyholder Bank Details

Name of the Bank Account Holder Mr. Mrs. Ms.

Bank Account No.: _____ Account: Saving Current

Name of the Bank _____

Branch _____

MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank) _____

IFSC Code (11 character code appearing on your cheque leaf) _____

I Wish: Any refund due on the premium payment / any payment / claims will be directly credited to my aforesaid Bank Account.*

*As per IRDAI, its mandatory that all payments made to the insured only through electronic mode.

Note: Please attach original cancelled cheque and a copy of PAN card for verification of the particulars provided in this regard.

Aadhaar based Payment (For Reimbursement claims)

Aadhaar Card No.: _____ (Note: **Self Attested** Aadhaar card copy to be submitted)

I wish to collect claim reimbursement directly in my Bank account linked with my aforementioned Aadhaar Card. I understand that the claim amount shall be credited directly in my latest Bank account linked with my Aadhaar Card.

I/We hereby declare that the details given above are true and correct to the best of my belief and knowledge. In the event above information or any part thereof is found incorrect, I agree that all right under the policy will be forfeited. I agree to provide additional information to the Company if required. I will indemnify and hold harmless the Company due to any loss arising out of misstatement in this form and am willing if required, to make a statutory Declaration before a Justice of the Peace of the truth of the whole of the foregoing statement or any other statement I may make in connection with this claim.

I further agree and undertake not to receive from Reliance General Insurance Company Limited any rebate other than that mentioned in the published prospectus in accordance with the provisions Section 41 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015.

Place: _____

Date:

(Signature of Insured Person/Claimant)