



General Insurance

Reliance Inland Travel Care Policy
Claim Form A

Hospitalization expenses/ Emergency medical expenses

In case of disease/illness

Please provide the details of the disease/illness

Please provide the cause of the disease/illness

Date of onset of disease/illness

In case of accident

Please provide the details of the accident

Please provide the cause of the accident

Date of accident Place of the accident

Please specify whether the Patient/Insured person was hospitalized for treatment of disease/illness/injury: Yes No

If yes, period of Hospitalization/Treatment done for disease/illness/injury: From To

Nature of Treatment done for disease/illness/injury

Name of Hospital/ Nursing Home where treatment of the disease/illness/injury was given:

Address

Flat Building Road/Street/Sector

Area

Taluka/Village/District/City Pin Code State

Country Fax

Telephone No.

Name of the Attending Doctor/Physician Dr.

Address

Flat Building Road/Street/Sector

Area

Taluka/Village/District/City Pin Code State

Country Telephone

Mobile E-mail

Fax

Was the disease/illness/injury caused and/or aggravated by any pre-existing condition/disease/illness/injury? Yes No

b. Has the Patient/Insured person been treated for the disease/illness/injury? Please specify the necessary details of the treatment received

c. Name of the Consulted Physician: Dr.

Attending Physician's Statement
(To be filled up by the Attending Doctor/Physician)

Please provide the following details of the Patient/Insured Person

Name Mr. Mrs. _____
Age _____ Sex M F
Address
Flat Building _____ Road/Street/Sector _____
Area _____
Taluka/Village/District/City _____ Pin Code _____ State _____
Country _____ Fax _____
Email Id: _____ Phone No. _____

Please specify the date & time when the Patient/Insured Person first contacted you _____

Please provide the details of the diagnosis and treatment given for the disease/illness/ injury _____

Please provide the details of medical investigation done, if any _____

In case of accidental injury

Does the cause of accident as stated by the Patient/Insured Person tally with the injuries noticed by you? _____

Was the Patient/Insured Person suffering from any condition/disease/illness/injury which may have contributed to the accident or likely to aggravate his/her condition: Yes No

If yes, please specify the necessary details _____

Was the Patient/Insured Person under the influence of alcohol or intoxicants or drugs at the time of accident? Yes No

If yes, please specify the necessary details _____

In case of disease/illness

When did the Patient/ Insured Person's symptoms first appear? _____
Please specify the cause of the disease/illness _____

Was the disease/illness caused and/or aggravated due to any pre-existing condition/ disease/illness/injury ? Yes No

If yes, please give the necessary details: _____

Is the condition due to pregnancy? Yes No

Was the Patient/Insured Person hospitalized for the treatment of the disease/illness/injury? _____

If yes, please provide the following details

Period of Hospitalization: From [d | d | m | m | y | y | y | y] to [d | d | m | m | y | y | y | y]

Name of Hospital/ Nursing Home where treatment of the disease/illness/injury was given:

Address
Flat Building _____ Road/Street/Sector _____
Area _____
Taluka/Village/District/City _____ Pin Code _____ State _____
Country _____ Fax _____

Name of the attending Doctor/Physician Dr. _____

Address

Flat Building _____ Road/Street/Sector _____

Area _____

Taluka/Village/District/City _____ Pin Code _____ State _____

Country _____ Fax _____

Email Id _____ Telephone _____

Mobile No _____

Date: | d | d | | m | m | | y | y | y | y |

Attending Doctor's/Physician's Signature

Place:

Proposer's Bank Details

Name of the Bank Account Holder Mr. Mrs. Ms. | F | I | R | S | T | | M | I | D | D | L | E | | L | A | S | T |

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 IRDA, its mandatory that all payments made to the insured only through electronic mode.