To ensure priority processing, please complete all sections in CAPITAL letters. Please tick ☑ in the relevant boxes.

CLAIM FORM FOR HEALTH INSURANCE POLICIES

OTHER THAN TRAVEL AND PERSONAL ACCIDENT

The issue of this form is not to be taken as an admission of liability.

(Guidance for filling claim form - **Part A** is available on our website: www.royalsundaram.in)

Royal Sundaram
General Insurance

PART A

DETAILS OF PRIMARY INSURED (PROPOSER) **(TO BE FILLED IN BY THE INSURED)**

SECTION A

a) Policy No. | b) Sl. No./ Certificate No.

c) Membership No./ TPA ID No.

d) Name

e) Address

City | State

Pin Code | Land Line (with STD Code)

Mobile No. | Email ID

Alternate Email ID

DETAILS OF INSURANCE HISTORY:

SECTION B

a) Currently covered by any other Mediclaim/Health Insurance ☐ Yes ☐ No

b) If yes, Company Name

Policy No. | c) Date of commencement of first Insurance without break (D D M M Y Y Y Y)

d) Sum Insured (Rs.) | e) Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No | f) Date (M M Y Y Y Y)

g)Diagnosis

DETAILS OF INSURED PERSON HOSPITALIZED:

SECTION C

a) Name

b) Gender ☐ Male ☐ Female | c) Age ____ Years (Y Y) Months (M M) | d) Date of Birth (D D M M Y Y Y Y)

e) Relationship to Primary insured ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please Specify) _____

f) Occupation ☐ Doctor ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please Specify) _____

g) Address (if different from above)

City | State

Pin Code | Land Line (with STD Code)

DETAILS OF HOSPITALIZATION

SECTION D

a) Name & Address of Hospital where Admitted

City | State

Pin Code | Land Mark

b) Room Category occupied ☐ Day care ☐ Single occupancy ☐ 3 or more beds per room ☐ Any other category, Pls specify _____

c) Hospitalization due to ☐ Injury ☐ Illness ☐ Maternity | d) Date of Injury/Date Disease first detected (D D M M Y Y Y Y)

e) Date of Admission (D D M M Y Y Y Y) Time (H H : M M) | f) Date of Discharge (D D M M Y Y Y Y) Time (H H : M M)

g) In case of maternity, Date of Delivery (D D M M Y Y Y Y) | Gravida Status _____

h) If Injury, give cause ☐ Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption

1. If Medico legal ☐ Yes ☐ No 2. Reported to police ☐ Yes ☐ No 3. MLC Report & Police FIR attached ☐ Yes ☐ No

i) System of Medicine _____

DETAILS OF CLAIM:

a) Details of the treatment expenses claimed

1. Pre-hospitalization Expenses	Rs.	2. Hospitalization Expenses	Rs.
3. Post-hospitalization Expenses	Rs.	4. Health-Check up Cost	Rs.
5. Ambulance Charges	Rs.	6. Others	Rs.
		Total (1 to 6)	Rs.

b) Claim for Domiciliary Hospitalization ☐ Yes ☐ No (If yes, please provide summary of bills in separate sheet)

c) Details of Lump sum / cash benefit claimed:

1. Hospital Daily Cash	Rs.	2. Surgical Cash	Rs.
3. Critical Illness Benefit	Rs.	4. Convalescence	Rs.
5. Pre/Post hospitalization Lump sum benefit:	Rs.	6. Others_____	Rs.
		Total (1 to 6)	Rs.

SECTION E

Claim Documents to be submitted - Check List:

- ☐ Claim Form Duly signed
- ☐ Copy of the claim intimation, if any
- ☐ Hospital Main Bill
- ☐ Hospital Break-up Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bill
- ☐ Doctor's request for investigation
- ☐ Investigation Reports (Including CT/MRI/USG/HPE/ECG)
- ☐ Doctor's prescription for medicines purchased outside the hospital
- ☐ Test report and prescription relating to first consultation for the illness
- ☐ Hospital advance and final receipts
- ☐ FIR/MLC in case of accident injury and English translation of the same if it is in any other language
- ☐ KYC document (Address proof, ID proof, for claims exceeding Rs. 1 Lakh)
- ☐ Others_____

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1		D D M M Y Y Y Y		Hospital Main Bill	
2		D D M M Y Y Y Y		Pre-hospitalization Bills: Nos_____	
3		D D M M Y Y Y Y		Post-hospitalization Bills: Nos_____	
4		D D M M Y Y Y Y		Pharmacy Bills: Nos_____	
5		D D M M Y Y Y Y			
6		D D M M Y Y Y Y			
7		D D M M Y Y Y Y			
8		D D M M Y Y Y Y			
9		D D M M Y Y Y Y			
10		D D M M Y Y Y Y			

SECTION F

Note : Please attach separate sheet if necessary

In case of claim settlement, Do you wish to settle ☐ **By Cheque** ☐ **By NEFT**

In case of NEFT, Please provide the below details:

a) PAN

b) Account Number

c) Bank Name and Branch

d) IFSC Code

SECTION G

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / insurance company, to seek necessary medical information/documents from any hospital/Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills/receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date D D M M Y Y Y Y Place

Signature of the Primary Insured

SECTION H

Royal Sundaram Alliance Insurance Company Limited
Corporate Office: Sundaram Towers, 45 & 46, Whites Road, Chennai-600 014.
Registered Office: 21, Patullos Road, Chennai - 600 002.

1860 425 0000 | **customer.services@royalsundaram.in** | **www.royalsundaram.in**

To ensure priority processing, please complete all sections in CAPITAL letters. Please tick ☑ in the relevant boxes.

CLAIM FORM – PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of this Form is not to be taken as an admission of liability

(Guidance for filling claim form- **Part B** is available on our website: www.royalsundaram.in)

Royal Sundaram
General Insurance

DETAILS OF HOSPITAL

SECTION A

a) Name of the hospital

b) Hospital ID
(For Office use only)

c) Type of Hospital ☐ Network ☐ Non Network (If non network fill section E)

d) Name of the treating Doctor

e) Qualification

f) Registration No. with State Code

g) Phone

DETAILS OF THE PATIENT ADMITTED

SECTION B

a) Name of the Patient:

b) IP Registration Number

c) Gender ☐ Male ☐ Female c) Age ____ Years Y Y Months M M e) Date of Birth D D M M Y Y Y Y

f) Type of Admission ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity

g) Date of Admission D D M M Y Y Y Y Time H H : M M

h) Date of Discharge D D M M Y Y Y Y Time H H : M M

i) If Maternity

1.Date of Delivery D D M M Y Y Y Y Gravida Status _____

j) Status at time of discharge ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased

DETAILS OF AILMENT DIAGNOSED

SECTION C

a)	ICD 10 Codes	Description	Duration
1. Primary Diagnosis			M M Y Y Y Y
2. Additional Diagnosis			M M Y Y Y Y
3. Co-morbidities			M M Y Y Y Y
4. Co-morbidities			M M Y Y Y Y
	ICD 10 PCS Codes		
1. Procedure(1)			
2. Procedure(2)			
3. Procedure(3)			
4. Details of any other Procedure			

b) Hospitalization due to Injury ☐ Yes ☐ No If Yes, give cause

1. ☐ Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse/alcohol consumption

2. If Injury due to Substance abuse/alcohol consumption, Test Conducted to establish this: ☐ Yes ☐ No

If Yes, details of tests conducted _____

3. If Medico legal ☐ Yes ☐ No 4. Reported to Police ☐ Yes ☐ No 5. FIR No. _____

6. If not reported to police, give reason _____

c) When did the patient start suffering with the complaint? _____ Date of first consultation (prior to hospitalisation) D D M M Y Y Y Y

d) Please give previous medical history of the patient

e) Is the patient suffering from any of the following diseases. If "yes" Please mention the duration below.

		Say Yes/No	Duration in Year	Duration in Month
1.	Bronchial Asthma			
2.	Chronic Obstructive Pulmonary disease			
3.	Hypertension			
4.	Diabetes			
5.	Heart ailment			
6.	Osteoarthritis			
7.	Cerebro vascular attack			
8.	Seizure disorder			
9.	Renal/Kidney Disorder			
10.	Any other			

f) Is the ailment a complication of a pre-existing disease or condition? If Yes , please give details

g) History of alcoholism ☐ Yes ☐ No
If yes : No of years _____
Quantity consumed per day _____

h) History of Smoking/ Tobacco chewing ☐ Yes ☐ No
If yes : No of years _____
Units consumed per day _____

ADDITIONAL DETAILS IN CASE OF NON-NETWORK HOSPITAL

SECTION D

a) Address of the Hospital

b) Hospital Registration No

c) Hospital Registered with

City State

d) Hospital PAN e) Number of Inpatient beds

f) Facilities available in the hospital: 1. OT ☐ Yes ☐ No 2. ICU ☐ Yes ☐ No 3. Doctor/Round the clock Nurses ☐ Yes ☐ No
4. Others _____

DECLARATION BY THE HOSPITAL **(PLEASE READ VERY CAREFULLY)**

SECTION E

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, insured's right to claim under this policy shall be forfeited.

Date D D M M Y Y Y Y Place

Signature and Seal of the Hospital Authority

PR130263/SEP13