Universal Sompo General Insurance
Suraksha, Hamesha Aapke Saath

# REIMBURSEMENT CLAIM FORM
**TO BE FILLED IN BY THE INSURED**
**The issue of this form is not to be taken as admission of liability**

## DETAILS OF PRIMARY INSURED (To be filled in block letters)

SECTION A

a) Policy no: b) Sl. No/ Certificate No:

c) Universal Sompo Health Serve Card No:

d) Name:

e) Address:

City: State:

Pin Code: Phone No: Email ID:

## DETAILS OF INSURANCE HISTORY

SECTION B

a) Currently covered by any other Mediclaim/ Health Insurance: Yes No b) Date of commencement of first insurance without break:

c) If yes, company name: Policy No:

Sum Insured (`): d) Have you been hospitalized in the last four years since inception of the contract? Yes No Date:

Diagnosis: e) Previously covered by any other Mediclaim/ Health Insurance : Yes No

f) If yes, Company Name :

## DETAILS OF INSURED PERSON HOSPITALIZED

SECTION C

a) Name :

b) Gender : Male Female c) Age: years months d) Date of Birth:

e) Relationship to Primary Insured: Self Spouse Child Father Mother Other (Please specify)

f) Occupation: Service Self Employed Homemaker Student Retired Other (Please specify)

g) Address (if different from above):

City: State:

Pin Code: Phone No: Email ID:

## DETAILS OF HOSPITALIZATION

SECTION D

a) Name of Hospital where Admitted:

b) Room category occupied: Day Care Single occupancy Twin sharing 3 or more beds per room

c) Hospitalization due to: Injury Illness Maternity d) Date of injury/ Date Disease first detected/ Date of Delivery:

e) Date of Admission: f) Time: : g) Date of Discharge: h) Time: :

i) If injury, give cause: Self inflicted Road Traffic Accident Substance abuse / Alcohol Consumption i. If Medico Legal: Yes No

ii. Reported to police: Yes No iii. MLC Report & Police FIR attached: Yes No j) System of medicine:

## DETAILS OF CLAIM

SECTION E

a) Details of treatment expenses claimed

i. Pre Hospitalization Expenses ₹
ii. Hospitalization Expenses ₹
iii. Post Hospitalization Expenses ₹
iv. Health Check up Cost ₹
v. Ambulance Charges ₹
vi. Others (code): ₹
**Total** ₹
vi. Pre hospitalization period: days
vii. Pre hospitalization period: days

b) Claim for Domiciliary Hospitalization: Yes No (if yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily Cash: ₹
ii. Surgical Cash: ₹
iii. Critical Illness Benefit: ₹
iv. Convalescence: ₹
v. Pre/Post hosp. Lump sum benefit: ₹
vi. Others: ₹
**Total** ₹

**Claim Documents Submitted- Check List:**

- Claim FormDuly signed
- Copy of the claim intimation, if any
- Hospital Main bill
- Hospital Break-up bill
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theatre Notes
- ECG
- Doctor's request for investigation
- Investigation Reports (including CT / MRI / USG / HPE)
- Doctor's Prescription
- Others

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## DETAILS OF BILLS ENCLOSED

SECTION F

| Sl. No. | Bill No. | Date | Issued By | Towards | Amount (₹ |
|---|---|---|---|---|---|
| 1 | | | | Hospital Main Bill | |
| 2 | | | | Pre hospitalisation Bills: ___ Nos | |
| 3 | | | | Post hospitalisation Bills: ___ Nos | |
| 4 | | | | Pharmacy Bills: | |
| 5 | | | | | |
| 6 | | | | | |
| 7 | | | | | |
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## DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

SECTION G

a) PAN: b) Account Number:

c) Bank Name and Branch

d) Cheque/ DD Payable details: e) IFSC Code:

## DECLARATION BY THE INSURED

SECTION H

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 Universal Sompo GIC Ltd, 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: Place: Signature of the insured: