



Toll Free Helpline: 1800 200 4030

UNIVERSAL SOMPO GENERAL INSURANCE COMPANY LIMITED

TO BE FILLED BY THE HOSPITAL

TO BE FILLED BY THE INSURED / PATIENT

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

(PLEASE COMPLETE DECLARATION OF THIS FORM)

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DETAILS OF PATIENT ADMITTED

a) Date of admission: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		b) Time: <input type="text"/> : <input type="text"/>		d) Mandatory : Past history of any chronic illness		If Yes, since(month /year)	
c) Is this an emergency / a planned hospitalization event?		<input type="checkbox"/> Emergency <input type="checkbox"/> Planned		<input type="checkbox"/> Diabetes		<input type="text"/> <input type="text"/>	
e) Expected no. of days/ Stay in hospital: <input type="text"/> Days		f) Days in ICU: <input type="text"/> Days		<input type="checkbox"/> Heart Disease		<input type="text"/> <input type="text"/>	
g) Room Type		:		<input type="checkbox"/> Hypertension		<input type="text"/> <input type="text"/>	
h) Per Day Room Rent + Nursing & Service Charges + Patient's Diet		: ₹		<input type="checkbox"/> Hyperlipidemias		<input type="text"/> <input type="text"/>	
i) Expected cost of investigation + diagnostic		: ₹		<input type="checkbox"/> Osteoarthritis		<input type="text"/> <input type="text"/>	
j) ICU Charges		: ₹		<input type="checkbox"/> Asthma / COPD / Bronchitis		<input type="text"/> <input type="text"/>	
k) OT Charges		: ₹		<input type="checkbox"/> Cancer		<input type="text"/> <input type="text"/>	
l) Professional fees Surgeon + Anesthetist Fees + consultation charges		: ₹		<input type="checkbox"/> Alcohol/ Drug abuse		<input type="text"/> <input type="text"/>	
m) Medicines + Consumables + Cost of implants (if applicable, please specify), other hospital expenses, if any		: ₹		<input type="checkbox"/> Any HIV/ or STD Related ailments		<input type="text"/> <input type="text"/>	
n) Other hospital expenses if any		: ₹		<input type="checkbox"/> Any other Ailment, give details:			
o) All inclusive package charges, if any applicable		: ₹					
p) Sum Total expected cost of hospitalization		: ₹					

DECLARATION

We confirm having read understood and agreed to the Declarations of this form

a) Name of the treating Doctor:	<input type="text"/>	b) Qualification:	<input type="text"/>
c) Registration number with state code:	<input type="text"/>		
<input type="text"/> Hospital Seal (must include hospital ID)		<input type="text"/> Patient / Insured Name & Signature	

DECLARATION BY THE PATIENT / REPRESENTATIVE

- I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Universal Sampo General Insurance Company Ltd after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
- Payment to hospital is governed by the terms and conditions of the policy. In case the Universal Sampo General Insurance Company Ltd is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
- All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Universal Sampo General Insurance Company Ltd not governed by the terms and conditions of the policy will be paid by me. In case any clarification is needed on admissibility of a particular item I shall contact Insurance Company at the Toll Free Number on the reverse of this form.
- I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Universal Sampo General Insurance Company Ltd.
- I agree and understand that Insurer is in no way warranting the service of the hospital & that the Universal Sampo General Insurance Company Ltd is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
- I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.
- I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Universal Sampo General Insurance Company Ltd.
- I/We authorize Universal Sampo General Insurance Company Ltd to contact me/us through mobile/email for any update on this claim.

a) Patient's / Insured's Name:	<input type="text"/>		
b) Contact number:	<input type="text"/>	c) Email ID (optional):	<input type="text"/>
d) Patient's / Insured's Signature:	<input type="text"/>	e) Date	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
		Time:	<input type="text"/> : <input type="text"/>

(IMPORTANT: PLEASE TURN OVER)

HOSPITAL DECLARATION

1. We have no objection to any authorized Insurance Company official verifying documents pertaining to hospitalization.
2. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to Universal Sampo General Insurance Company Ltd Company within 7 days of the patient's discharge.
3. All non-medical expenses, OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the Universal Sampo General Insurance Company Ltd, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.
4. WE AGREE THAT INSURANCE COMPANY WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY or other documents.
5. The patient declaration has been signed by the patient or by his representative in our presence.
6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
7. We will abide by the terms and conditions agreed in the MOU.
8. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility choosing separate line of treatment which is not envisaged/ considered in package).
9. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package).
10. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, Universal Sampo General Insurance Company Ltd reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MOU or applicable laws.

Hospital Seal

Doctor's Signature

Date

Time: :

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.

*As per IRDA circular Ref: IRDA/SDD/GDL/CIR/020/02/2013 Anti-Money Laundering /Counter Financing of Terrorism (AML/CFT)-Guidelines for General Insurers. All general insurance companies are required to carry out KYC norms at the settlement stage where claim payout crosses a threshold of ` One lakh per claim. In cases where payments are made to third party service providers such as hospitals, the KYC norms shall apply on the customers on whose behalf service providers act.