IFFCO-TOKIO GENERAL INSURANCE CO. LTD.

Regd. Office: 34, Nehru Place, New Delhi-110019
Pune Branch Office: A-301, Kapil Towers, 45 Ambedkar Road, Near RTO, Pune-411001

MEDISHIELD CLAIM FORM

Issuance of this form does not amount to admission of any liability under claim on the part of the Insurers.

Please give the following information correctly and completely to enable the Company to process your claim promptly.

Policy No.	
Name of the Insured (in whose name policy is issued)	
Details of Insured Person (in respect of whom claim is made) Name/relationship to the Insured Present completed Age Occupation Residential address	
Nature of Disease/illness contracted or injury suffered	
Date of injury sustained or Disease/illness first detected	

Name & Address of the attending Medical Practitioner Qualification & Tel. No. Registration No.	
Name & Address of the Hospital/Nursing Home/Clinic Date of Admission	Date Month Year
Date of Discharge	Date Month Year
If the Claim is for Domiciliary Hospitalisation, please indicate Date of Commencement of Treatment Date of Completion of treatment Name & Address of attending Medical Practitioner Telephone No. Registration No.	Date Month Year Date Month Year

I have incurred on the treatment of Disease/illness/Accident referred to above, the expenses as per the details given by me in the Schedule of Expenses given Overleaf.

In support of the above claim I enclose the following documents (please indicate by):

1. Bill, Receipts and Discharge Certificate/Card for the Hospital.
2. Cash Memos from the Hospital Chemist(s) supported by the proper prescription.
3. Receipt and Pathological test reports from a pathologist supported by the note from the attending Medical Practitioner/Surgeon demanding such Pathological tests.
4. Surgeon's certificate starting nature of operation performed and Surgeon's bill and receipt.
5. Attending Doctor's / Consultant's / Anaesthetist's bill and receipt and certificate regarding diagnosis.

6. In case of domiciliary hospitalisation, receipt from a qualified nurse who attended the Patient at his/her residence duly supported by a certificate from attending Medical Practitioner.
7. Certificate from the attending Medical Practitioner giving reasons for allowing treatment at home.
8. Certificate from the attending Medical Practitioner/Surgeon that the Patient is fully cured.

I/We hereby warrant the truth of the foregoing 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.

Dated: This _____ Day of _____2002

Signature of the Claimant