UNITED INDIA INSURANCE CO LTD
REGIONAL OFFICE, VADODARA
CIN:U93090TN1938GOI000108

CASHLESS CUM DECLARATION FORM **Date:-**
(Mandatory in each health claim file)

Name of Patient:..... Age:..... Gender: .....

DOA:.....Time of Admission:.....

PART I: Cashless Request:
Time of cashless Request:.....

Cashless request of aforementioned patient is attached herewith.

Sign of Patient or Kin of patient
with name & relation

Sign of authorized hospital staff
with seal.

PART II: Declaration, in case cashless request is not made:

I, ..., Patient/ relative of patient/ family member of patient, having UIIC policy no....., have been made aware of cashless facility that is available in the hospital for UIICL policy holders and I/ Patient am/ is declining it for personal reasons. I am aware that if/ when I will put up my file for reimbursement health claim, it will be settled as per cashless agreement of hospital with UIICL. I/ Patient agree that this information was furnished to me, in advance and that not availing cashless is my/ patient's decision.

Sign of Patient or Kin of patient
with name & relation

Sign of authorized hospital staff
with seal.

PART III: In case patient claims to have no health insurance:

I,....., Patient/ relative of patient/ family member of patient, have been made aware of cashless facility that is available in the hospital for UIICL policy holders and hereby declare that I/ patient does not have any health insurance and I/ patient agree that at a later date, if it was found out that I/ patient was holder of UIIC health policy and put up claim for reimbursement for current hospitalization then claim will be settled based on the lower of the two viz: cashless agreement or actual expenses.

Sign of Patient or Kin of patient
with name & relation

Sign of authorized hospital staff
with seal.