

Hospital Cash/Medical Expenses

Claim Form



WITH YOU ALWAYS

IMPORTANT:

1. Issuance of this form is not an admission of Liability or a waiver of the terms, conditions and exceptions of the insurance contract.
2. If the space provided is insufficient, please attach additional sheets.

Policy No.

Claim No.

1. DETAILS OF INSURED

Name

First Name

Middle Name

Surname

Address

City

State

PIN

Phone (O)

(R)

Mobile

E-mail

Name of the contact person

Designation

Tel

Fax

E-mail

2. DETAILS OF SICKNESS

Time and Date

D D M M Y Y Y Y

Diagnosis

Place and Location

Address

City

State

PIN

3. TREATMENT DETAILS

Name of the Attending Doctor

Tel

Fax

E-mail

Date(s) of Consultation

D D M M Y Y Y Y

Name of the Hospital(s)
(If hospitalized)

Address

City

State

PIN

Tel

Fax

E-mail ID

Period of hospitalization:

From

D D M M Y Y Y Y

to

D D M M Y Y Y Y

Diagnosis/Surgery

4. AMOUNT OF EXPENSES

Please attach a separate sheet if the space is insufficient.

a) In hospital cash (If covered).

From	To	Amount

Have the Police Authorities been informed of this accident?

Yes ☐ No ☐

I hereby declare that I have suffered injuries as described above and all the details given are **ABSOLUTELY TRUE AND CORRECT**. I hereby agree to forfeit all my rights to compensation if any of the foregoing facts and/or details are found to be false or incorrect. I further authorise the hospital, doctor diagnostic laboratory, organisation, establishment or any other body or person dealt with in the course of this claim to give any information or document sought for by the Insurance Company.

Date: _____

Place: _____

Signature of the Insured _____

ATTENDING PHYSICIAN'S STATEMENT

PLEASE ANSWER ALL QUESTIONS

Name & Age of Injured Person: _____

Address _____

City _____

State _____ PIN _____

Phone (O) _____ (R) _____

Fax _____ Mobile _____

Details of the Sickness : _____

Was the injured person suffering from any disease : _____

Was the Claimant hospitalized? If so for what period? _____

What treatment was given and Operations performed? _____

Give all dates of treatment : _____

Home: From _____ To _____ Clinic/Hospital: Form _____ To _____

Are you his usual medical Attendant ? _____

If you have treated him for any previous illness,
Please give details. _____

Have other Doctors been in Attendance or Consultation?
If yes, Please give details. _____

What is the Prognosis? _____

Doctor's Signature _____ Date _____ Regn No. _____

Doctors Name & Seal: _____

Address _____

City _____

State _____ PIN _____

Phone (O) _____ (R) _____

Fax _____ Mobile _____

Tata AIG General Insurance Company Limited

Registered office: Peninsula Business Park, Tower A, 15th Floor, G. K. Marg, Off Senapati Bapat Road, Lower Parel, Mumbai - 400 013.

For more information visit us at; Email us at customersupport@tata-aig.com or visit www.tataaiginsurance.in
Contact us on our 24 hour Toll Free Helpline at 1800 266 7780 or 1800 22 9966 (only for senior citizen policy holders)
Insurance is the subject matter of the solicitation