RELIANCE
General Insurance

reliancegeneral.co.in
1800 209 55 22

Reliance Travel Care Insurance Policy
Claim Form A

Medical Expenses/Dental Care Expenses

1. **In case of disease/illness**

   Please provide the details of the disease/illness _____

   _____

   Please provide the cause of the disease/illness _____

   _____

   Date of onset of disease/illness d d m m y y y y

2. **In case of accident**

   Please provide the details of the accident _____

   _____

   Please provide the cause of the accident _____

   _____

   Date of accident d d m m y y y y

   Place of the accident _____

3. Please specify whether the Patient/Insured person was hospitalized for treatment of disease/illness/injury: ☐ Yes ☐ No

   If yes, period of Hospitalization/
   Treatment done for disease/illness/injury: From d d m m y y y y To d d m m y y y y

4. Nature of Treatment done for disease/illness/injury _____

   _____

5. Name of Hospital/Nursing Home where treatment of the disease/illness/injury was given: _____

   _____

6. Address
   Flat/Building/Door/Block No. _____
   Road/Street/Sector _____
   Area _____
   Taluka/Village/District/City _____ Pin Code _____
   State _____ Country _____
   Telephone No. _____ Fax _____

7. Name of the Attending Doctor/Physician Dr. _____

8. Address
   Flat/Building/Door/Block No. _____
   Road/Street/Sector _____
   Area _____
   Taluka/Village/District/City _____ Pin Code _____
   State _____ Country _____
   Telephone No. _____ Mobile _____
   Email _____ Fax _____

In case of a claim under any of the add-on benefits, please fill in the following details
(Applicable only if the Insured Person has opted for the additional add-on benefits under the Student Plan)

Sr. No.	Coverage	Total Expenses
1.	Treatment of Mental and Nervous Disorders including Alcohol and Drug Dependency	
2.	Impatient Hospitalization expenses related to Pregnancy/Child birth.	
3.	Medical Expenses for Inter collegiate sports injuries.	
4.	Cancer Screening and Mammographic Examinations.	
5.	Child Care Benefits	
6.	Chiropractic Treatment	
7.	Physiotherapy Treatment	
8.	Skilled Nursing Treatment	

a. Was the disease/illness/injury caused and/or aggravated by any pre-existing condition/disease/illness/injury? ☐ Yes ☐ No
If yes,

b. Has the Patient/insured person been treated for the disease/illness/injury? Please specify the necessary details of the treatment received

_____

c. Name of the Consulted Physician: Dr. _____

d. Address of the Consulted Physician

Flat/Building/Door/Block No. _____

Road/Street/Sector _____

Area _____

Taluka/Village/District/City _____ Pin Code _____

State _____ Country _____

Fax _____

e. Telephone Number of the Consulted Physician _____

Please specify the names of the prescription medicines that the Patient/Insured Person is presently taking, if any

_____

Please provide the details of the expenses related to your treatment

Detail of Expenses	In/Out Patient From	To	Charges (Currency)	Rupees
			Paid	
			Outstanding	
			Total Due	

f. Family Physicians Name _____

Contact No. _____ Email Id _____

g. Regular Dentist Name _____

Contact No. _____ Email Id _____

Repatriation of Remains/Emergency Evacuation

9. Date of Departure [d d m m y y y y] 10. Date of Arrival [d d m m y y y y]

11. Flight No. [ ] From _____ To _____

12. **In case of a claim for emergency evacuation:**

Cause of disease/illness/injury leading to evacuation: _____

Date of injury or commencement of disease/illness: [d d m m y y y y] Place _____

13. **In case of a claim for repatriation of remains/funeral expenses:**

Cause of Death _____

Date of Death [d d m m y y y y] Place of Death _____

14. Please provide the details of the expenses related to the repatriation/funeral/evacuation

Detail of Expenses incurred	Date	Place	Amount
		Total Due	

Attending Physician's Statement (To be filled up by the Attending Doctor/Physician)

15. Please provide the following details of the Patient/Insured Person

Name ☐ Mr. ☐ Mrs. [ ]

Age [ ] yrs Sex ☐ M ☐ F

Address
Flat/Building/Door/Block No. [ ]

Road/Street/Sector [ ]

Area [ ]

Taluka/Village/District/City [ ] Pin Code [ ]

State [ ] Country [ ]

Fax [ ] Email Id: [ ]

Phone No. [ ]

16. Please specify the date & time when the Patient/Insured Person first contacted you _____

_____

17. Please provide the details of the diagnosis and treatment given for the disease/illness/ injury _____

_____

18. Please provide the details of medical investigation done, if any _____

_____

19. **In case of accidental injury**

Does the cause of accident as stated by the Patient/Insured Person tally with the injuries noticed by you? _____

_____

Was the Patient/Insured Person suffering from any condition/disease/illness/injury which may have contributed to the accident or likely to aggravate his/her condition: ☐ Yes ☐ No

If yes, please specify the necessary details _____

_____

Was the Patient/Insured Person under the influence of alcohol or intoxicants or drugs at the time of accident? ☐ Yes ☐ No

If yes, please specify the necessary details _____

_____

20. **In case of disease/illness**

When did the Patient/ Insured Person's symptoms first appear? _____

Please specify the cause of the disease/illness _____

_____

Was the disease/illness caused and/or aggravated due to any pre-existing condition/ disease/illness/injury ? ☐ Yes ☐ No

If yes, please give the necessary details: _____

_____

Is the condition due to pregnancy? ☐ Yes ☐ No

Was the Patient/Insured Person hospitalized for the treatment of the disease/illness/injury? _____

_____

If yes, please provide the following details

Period of Hospitalization: From d d m m y y y y to d d m m y y y y

Name of Hospital/ Nursing Home where treatment of the disease/illness/injury was given:

Address
Flat/Building/Door/Block No.

Road/Street/Sector

Area

Taluka/Village/District/City Pin Code

State Country

Fax

Name of the attending Doctor/Physician Dr.

Address
Flat/Building/Door/Block No.

Road/Street/Sector

Area

Taluka/Village/District/City Pin Code

State Country

Telephone No. Mob. No.

Fax Email ID

Date: d d m m y y y y

Attending Doctor's/Physician's Signature

Place: _____

Compassionate Visit

21. Please specify the details of disease/illness/injury: _____

_____

_____

22. Date of accident/onset of ailment:

23. Was the Patient/Insured Person hospitalized? ☐ Yes ☐ No

24. Period of Hospitalization: From d d m m y y y y To d d m m y y y y

25. Please provide the details of the treatment given: _____

_____

_____

26. Please provide the following details of the Hospital/Nursing Home where the treatment for disease/illness/injury was taken:

Name of the Hospital/ Nursing Home

Address
Flat/Building/Door/Block No.

Road/Street/Sector

Area

Taluka/Village/District/City

Pin Code

State

Country

Telephone No.

Mob. No.

Fax

Email ID

27. Was the disease/illness/injury caused due to or aggravated by any pre-existing condition/disease/illness/injury: ☐ Yes ☐ No

If yes, please specify the necessary details _____

_____

28. In the opinion of the treating doctor, how many days of hospitalization would the Patient/Insured Person require?

29. In the opinion of the treating doctor, is there a need for an attendant for the Patient/Insured Person: _____

_____

30. **Please fill in the following details, only in case the Patient/Insured Person has opted for the Reliance Travel Care Insurance Policy-Student Plan**

Please specify as to who has been hospitalized: ☐ Patient/Insured Person ☐ Immediate family member of the Insured Person

Name of the family member hospitalization: _____

Relationship with the Patient/Insured Person: _____