Leadership and beyond

दि न्यू इन्डिया एश्योरन्स कंपनी लिमिटेड
The New India Assurance Co. Ltd
India's Premier Multinational General Insurance Company

The New India Assurance Company Limited

Divisional Office-760400, Kodavath Shopping Complex,
Sub jail Road, Aluva-683101, Direct: 0484-2629747,
Mob no: 9446288742

CLAIM FORM FOR SIB SURAKSHA KAVACH-PERSONAL ACCIDENT DEATH/ HOSPITILIZATION EXPENSES

1. Name of insured : SIBL

2. Name of the Injured / Deceased Person :

   SIB Account No. :

   Date of Proposal/Enrolment under SIBSK :

3. a) Date & time of Accident: Date : Time: a.m./p.m

   b) Place of Accident :

   c) Description of Accident :

   d) Whether intimated to Police: Yes/No ; If yes Police Station :

   e) FIR/SDE No.: Date :

4. If Injury i) Nature of Injury:

   ii) Extent of Injury:

   iii) Medical Practitioner (Who has attended the patient):

   a) Name :

   b) Address:

   iv) Hospital/ Nursing Home (Where treatment is taken):

   a) Name :

   b) Address/Phone Numbers :

   v) Treatment Details :

   a) Period of Treatment :

   b) Date of Admission :

c) Date of Discharge :

vi) SCHEDULE OF EXPENSES INCURRED BYTHE CLAIMANT

Details of Expenses claimed under Hospitalisation/Domiciliary Hospitalisation. (to be supported by Bills/Receipts , Cash Memos etc.)	Amount Claimed Rs. (1)	Amount not payable Rs. (2)	Net Payable
A) HOSPITALISATION BENEFITS: a) Room Board, Nursing Expenses For ..... days..... b) IC Unit for .....days ..... Rs.....per day. B) SURGICAL & NON-SURGICAL DISEASE: a) Surge on & Anaesthetist fees..... .. b) Anaesthesia, Blood, Oxygen, Operation Theatre, Surgical Appliances ..... c) Diagnostic Materials & X-Ray d) Medical Practitioner Consultant and Specialist fees for Consultations / visits..... e) Medicines & Drugs: a) Supplied by Hospital ..... b) Purchased from Chemists..... TOTAL			

vii. In case of Disablement:

a) Disability Factor: Enclose Disability Certificate in Original

b) Certified by :

c) Claimed :

5. In case of Deatth

i) Post Mortem Report Date :

ii) Death Certificate Date :

iii) Legal heir Certificate / Date :

iv) Nominee's Name : Age:

Relation with deceased :

Address :

v) Claimed Amount :

In support of the above claim, I enclose the following documents (Please tick the documents enclosed).

1. Bill Receipt and Discharge Certificate/card from the Hospital
2. Cash Memos from the Hospital-/ Chemist (s), supported by proper prescription.
3. Receipt and Pathological test reports from a Pathologist supported by the note from the Hospital/Medical Practitioner / Surgeon demanding such Pathological tests.
4. Surgeon's certificate stating nature of operation performed and Surgeon's Bill & receipt.
5. Attending Doctor/ Consultant/ Specialist/ Anaesthetist's bill and receipt and certificate regarding diagnosis:-
6. Certificate from the attending Medical Practitioner/ Surgeon that the Patient is fully cured.
7. Police FIR
8. Death Certificate*
9. Postmortem Report duly attested by Police Officer.*
10. Legal heirship Certificate* (If there is no registered nominee)
11. Photo ID /Address Proof of Registered Nominee / Legal heir
12. Copy of PAN Card of claimant (If claim amount exceeds Rs.1.00 lakh)

***applicable for death claims only.**

I 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 at ..... this ..... day of .....20.....

SIGNATURE OF CLAIMANT

ECS Details of the Insured (Please attach copy of Bank Pass Book or Cancelled cheque leaf)

1	Name of the Insured (as appearing in the Bank Account)	
2	Bank Name	
3	Branch and address	
4	Bank Account No.	
5	Bank Account Type	
6	IFSC Code	
7	MICR Code	