THE NEW INDIA ASSURANCE CO. LTD.,
Regd. & Head Office: 87, M.G. Road, Fort, Mumbai- 400 001.

UNIVERSAL HEALTH INSURANCE POLICY for APL FAMILIES

Policy issuing office

CLAIM FORM
(Please fill up the relevant sections)

Name of the insured:
Address of the insured:

Policy Number: Period of Insurance:

SECTION I

A) HOSPITALISATION EXPENSES

Name of the patient: Age: Sex:

Nature of Illness: Name of treating doctor
Name of Hospital

Date of Admission: Date of Discharge:

Amount:

B) DISABILITY COMPENSATION:
Amount:

Date of Admission: Date of Discharge:
Amount:

*Please attach discharge card, bills, cash memos, diagnostic reports etc.

SECTION II
PERSONAL ACCIDENT COVER TO EARNING HEAD OF THE FAMILY

Name of the insured:

Sex Age:

Date of accident: Date of death:

Details of accident in brief:

Date of intimation to Police:
Please submit FIR & Post Mortem Report

I declare that to the best of my knowledge all particulars contained in form are true

Date: Signature of the Claimant/Nominee
Place:

For Office Use Only:

SECTION I **Amount:**

A) Claim under Hospitalisation:
B) Claim for Disability Compensation
C) Claim under Maternity Benefit

SECTION II

PA CLAIM FOR DEATH
Total: