The Oriental Insurance Company Limited

Regd.Office:Oriental House,P.B.No.7037,A-25/27,Asaf Ali Road, New Delhi-110002
CIN No.U66010DL1947GOI007158

Oriental Critical Illness Policy

CLAIM FORM

TO BE FILLED IN BY THE INSURED **(To be filled in block letters)**

The issue of this form is not to be taken as admission of liability

SECTION A

DETAILS OF PRIMARY INSURED

a) Policy no: b) Company/ TPA ID No:

c) Name:

d) Address:

City: State:

Pin Code: Phone No: Email ID:

SECTION B

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim/ Health Insurance: Yes No b) Date of commencement of first insurance without break:

c) If yes, company name: Policy No:

Sum Insured (`): d) Have you been hospitalized in the last four years since inception of the contract? Yes No Date:

Diagnosis: e) Previously covered by any other Mediclaim/ Health Insurance : Yes No

f) If yes, Company Name :

SECTION C

DETAILS OF INSURED PERSON

a) Name :

b) Gender : Male Female d) Date of Birth: e) Sum insured: ` i) CB (if any)

f) Relationship to Primary Insured: Self Spouse Child Father Mother Other (Please specify)

g) Occupation: Service Self Employed Homemaker Student Retired Other (Please specify)

h) Address (if different from above):

City: State:

Pin Code: Phone No: Email ID:

SECTION D

DETAILS OF CLAIM

i. Name of the disease contacted

ii. Date of Diagnosis made [Please attach Certificate from the doctor confirming the Diagnosis]

iii. Name of the Institution giving the Diagnosis

iv. Present condition of the patient

DETAILS OF ENCLOSERS

Sl. No.	Ref No.	Date	Issued By	Towards
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

SECTION E

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN: b) Account Number:

c) Bank Name and Branch

d) Cheque/ DD Payable details: e) IFSC Code:

SECTION F

DECLARATION BY THE INSURED

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date: Place: Signature of the insured:

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GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
c) Name	Enter the full name of the policyholder	Surname, First name, Middle name
d) Address	Enter the full postal address	Include Street, City and Pin Code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name	Enter the full name of the insurance company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last 4 years since inception of the contract?	Indicate whether hospitalized in the last 4 years	Tick Yes or No
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF CLAIM		
a) Name of the disease contacted	Enter name of the covered disease contracted	
b) Date of Diagnosis made	Enter date when the covered disease was diagnosed (supported by doduments)	Use dd-mm-yy format
c) Name of the Institution giving the Diagnosis	Enter the name of institution diagnosing the disease	
d) Present condition of the patient	Enter present condition of insured	
SECTION E - DETAILS OF ENCLOSERS		
Supporting documents with respect to statements under Section D		
SECTION F - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		