

Reliance Travel Care Insurance Policy Claim Form A

	Medical Expenses/Dental Ca	re Expenses													
1.	In case of disease/illness														
	Please provide the details of the disease/illness														
	Please provide the cause of the	ne disease/illness													
	Date of onset of disease/illness	:[d,d[m,m]y,y,y]													
2.	In case of accident														
	Please provide the details of the	he accident													
	Please provide the cause of the	ne accident													
	Date of the accident	[d,d m,m y,y,y]													
	Place of the accident														
3.	Please specify whether the Pa	titient/Insured person was hospitalized for treatment of disease/illness/injury: ☐ Yes ☐ No													
	If yes, period of Hospitalization Treatment done for disease/ill	n/ ness/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 the 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 Pin Lode													
	State	Country Country													
	Telephone No.	Fax													
7.	Name of the Attending Doctor/F	Physician Dr. Landa Carlotte Landa C													
8.	Address														
	Flat/Building/Door/Block No.														
	Road/Street/Sector														
	Area														
	Taluka/Village/District/City	Pin Code													
	State	Country													
	Telephone No.	L Mobile L H													
	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 Expense	es
1.	Treatment of Mental and N	lervous Disorders incl	uding Alcohol	and Drug Dep	endency			
2.	Impatient Hospitalization e	expenses related to Pro	egnancy/Child	l birth.				
3.	Medical Expenses for Inter	r collegiate sports inju	ries.					
4.	Cancer Screening and Mai	mmographic Examina	tions.					
5.	Child Care Benefits							
6.	Chiropractic Treatment							
7.	Physiotherapy Treatment							
8.	Skilled Nursing Treatment							
	Vas the disease/illness/injury of yes,	caused and/or aggrav	ated by any p	re-existing con	dition/disease/illne	ess/injury?		∕es ☐ No
b. H	las the Patient/insured person eceived	on been treated for the	ne disease/illr	ness/injury? Pl	ease specify the	necessary	details of the	treatment
c. N	lame of the Consulted Physicia	an: Dr. L						
d. A	address of the Consulted Physi	ician						
F	lat/Building/Door/Block No.							
F	Road/Street/Sector							
A	Area							
Т	aluka/Village/District/City			Р	in Code L			
S	State			с	ountry			
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	ax elephone Number of the Con							
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	Repatriation of Remains/Em	ergency Evacuation												
9.	Date of Departure	[d	10. I	Date of Arriva	al [d d d	m m y	у гу гу							
11.	Flight No.		From			_ To								
12.	In case of a claim for emerg	ency evacuation:												
	Cause of disease/illness/injury leading to evacuation:													
	Date of injury or commencement of disease/illness:													
13.	3. In case of a claim for repatriation of remains/funeral expenses:													
	Cause of Death													
	Date of Death		Place of	Death										
14.	Please provide the details of the	he expenses related to the repatriation	n/funeral/e	evacuation										
	Detail of Expe	enses incurred		Date	PI	ace	Amount							
				1										
				1										
						Total Due								
Atter	nding Physician's Statement (To be filled up by the Attending Do	ctor/Phys	sician)										
15.	Please provide the following d	letails of the Patient/Insured Person												
	Name Mr. Mrs.													
	Age	yrs		Sex	М 🗆 F									
	Address						1							
	Flat/Building/Door/Block No.													
	Road/Street/Sector													
	Area			Din Code										
	Taluka/Village/District/City State													
	Fax													
	Phone No.			Liliali Iu. L										
16.		when the Patient/Insured Person first co		/OU										
10.	ricase specify the date a time (when the ration who are a resolution of	oritacioù y											
17.	Please provide the details of the	e diagnosis and treatment given for the	disease/il	Iness/injury_										
18.	Please provide the details of mo	edical investigation done, if any												
19.	In case of accidental injury													
	Does the cause of accident as s	stated by the Patient/Insured Person ta	lly with the	injuries notic	ed by you?_									
	Was the Patient/Insured Perso aggravate his/her condition:	on suffering from any condition/disease	e/illness/inj	iury which ma	y have conti	ibuted to the	accident or likely to							
	If yes, please specify the neces	ssary details												
		n under the influence of alcohol or intox					☐ Yes ☐ No							
	it yes, please specify the neces	ssary details												

Was the dispass/illness source	d and/or aggravated due to any pre-existing condition/ disease/illness/injury?	Yes 🗍
	ry details:	res 🗀
Is the condition due to pregnan	cy?	Yes 🗌
Was the Patient/Insured Perso	on hospitalized for the treatment of the disease/illness/injury?	
If yes, please provide the follow	ving details	
	rom [d_d m_m y_y_y_y] to [d_d m_m y_y_y_y]	
	ne where treatment of the disease/illness/injury was given:	
1		
Address		
Flat/Building/Door/Block No.		
Road/Street/Sector		
Area		
Taluka/Village/District/City	Pin Code Pin Code	
State	Country Country	
Fax		
Name of the attending Doctor	/Physician Dr	
Address Flat/Building/Door/Block No.		ı
Road/Street/Sector		
Area		
Taluka/Village/District/City		
State	Country	
Telephone No.	Mob. No	
Fax	Email ID	
IUA	LIII D	
	Date: [d_d]m_m y_y_y_y]	
Attending Doctor's/Physician	n's Signature Place:	
Compassionate Visit		
	he disease/illness/injury:	
r lease specify the details of the	ie disease/iiiiless/iiijuly.	
Date of accident/onset of ailm		, –
Was the Patient/Insured Person	· —	Yes _
Period of Hospitalization: F	From [d,d[m,m]y,y,y,y] To[d,d[m,m]y,y,y,y]	

20. In case of disease/illness

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26.	Please provide the following d	etails of	the I	Hosp	oital/I	Nursi	ing	Hon	ne v	whe	re th	e tı	reatr	nei	nt fo	or d	lisea	ase/i	llne	ss/	inju	ıry v	Nas	take	en:		
	Name of the Hospital/ Nursing	J Home			_	ш		1	1																		
	Address Flat/Building/Door/Block No.			1	1		L									1											
	Road/Street/Sector			1	1			1	_			_															1
	Area			1			L	1	_							_											
	Taluka/Village/District/City			1	1	ш							Pin	ı C	ode	L											1
	State					ш			ı				Со	unt	ry												
	Telephone No.					Ш							Мо	b.	No.	L											
	Fax			1		ш							Em	nail	ID												
27.	Was the disease/illness/injury caused due to or aggravated by any pre-existing condition/disease/illness/injury:												No														
	If yes, please specify the nece	ssary d	etails	·																							
28.	In the opinion of the treating d	loctor, he	ow m	any (days	of h	osp	oitali	zati	on	woul	d th	ne P	atie	ent/	Ins	ure	l Pe	rsor	n re	equi	ire?)				
29.	In the opinion of the treating d																										
	·	,																									
30.	Please fill in the following d Policy-Student Plan	etails, o	nly i	n ca	se tl	he P	atie	nt/lı	nsu	irec	l Per	so	n ha	as (pto	ed 1	for	the	Reli	and	ce -	Tra	vel	Car	e Ins	sura	nce
	Please specify as to who has	been ho	spita	lized	l:	P	atie	nt/In	sur	red	Pers	on		_ I	mn	ned	iate	fam	ily r	ner	nbe	er o	f the	e Ins	sure	d Pe	erson
	Name of the family member he	ospitaliz	ation	:																							
	Relationship with the Patient/I	nsured [Perso	on: _																							