

General Insurance

**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 the 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 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 _____
 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 _____

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 the 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: _____

Contact Reliance General Insurance Company Limited : +91-22-67347843* / +91-22-67347844*

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