

## THE NEW INDIA ASSURANCE CO. LTD.,

Regd. & Head Office: 87, M.G. Road, Fort, Mumbai- 400 001.

## **UNIVERSAL HEALTH INSURANCE POLICY for BPL FAMILIES**

Policy issuing office

## <u>CLAIM FORM</u> (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 Hospital	Name of treating doctor			
Date of Admission:	Date of Discharge:			
Amount:				
B) DISABILITY COMPENSATION: Amount:				
C) MATERNITY BENEFIT: Nature of Illness: Name of Hospital	* Name of treating doctor			
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 insure	ed:			
Sex	Age:			
Date of accident:		Date of death:		
Details of acciden	in brief:			
Date of intimation to Police: Please submit FIR & Post Mortem Report				
I declare that to the are true	e best of my k	nowledge all particulars containe	ed in forn	
Date: Place:	S	Signature of the Claimant/Nomin	ee	
For Office Use Only:  SECTION I  A) Claim under Hosp B) Claim for Disabili C) Claim under Mate SECTION II PA CLAIM FOR DE	ity Compensation ernity Benefit		mount:	
Total:				