GENERAL
INSURANCE

reliancegeneral.co.in
022 4890 3009 (Paid)
74004 22200

Corona Kavach Policy, Reliance General

Claim form for Health Insurance Policy other than Travel and Personal Accident - Part A

TO BE FILLED IN BY THE INSURED

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

(To be filled in BLOCK LETTERS)

SECTION A - DETAILS OF PRIMARY INSURED

a) Type of claim: ☐ Covid 19 Hospitalization expenses ☐ Pre Hospitalization ☐ Post Hospitalization ☐ Home Care Treatment ☐ Ayush Treatment ☐ Hospital Daily Cash

b) Pre authorization obtained ☐ Yes ☐ No

c) Policy type ☐ Individual ☐ Floater

d) Policy No ______ e) Certificate No/SI. No.: ______

f) Member ID No. ______

g) Proposer Name ______

h) Present completed age (in years) ______ i) Gender: ☐ Male ☐ Female

j) PAN No. ______

k) Address ______

City ______ State ______ Pin Code ______

Phone No ______ Email ID ______

l) Profession/Occupation ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Health Care Worker ☐ Other

m) Monthly Income: ☐ Up to ₹20,000 ☐ ₹20,001 to ₹50,000 ☐ ₹50,001 to ₹1,00,000 ☐ ₹1,00,001 and above

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 d d m m y y y y

c) If yes, company name ______

Policy No ______ Sum Insured ` ______

d) Have you been hospitalized in the last four years since inception of the contact? ☐ Yes ☐ No

Date d d m m Diagnosis ______

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

f) If yes Company Name ______

An ISO 9001:2015 Certified Company

Please courier documents to the below address:

RCare Health: Reliance General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad 500081.
Email: rgicl.rcarehealth@relianceada.com.

Reliance General Insurance Company Limited. IRDAI Registration No. 103. Registered & Corporate Office: Reliance Centre, South Wing, 4th Floor, Santacruz (East), Off. Western Express Highway, Mumbai 400055. Corporate Identity No.U66603MH2000PLC128300. UIN:RELHLIP21092V012021. Trade Logo displayed above belongs to Anil Dhirubhai Ambani Ventures Private Limited and used by Reliance General Insurance Company Limited under License.
RGI/MCOM/CO/CORONA-KAVACH -A- CLAIM /Ver. 1.0/210720.

SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED (Patient Details)

a) Name

b) Gender ☐ Male ☐ Female c) Age - ____________ years ___________Months d) Date of birth d d m m y y y y

e) Relationship to Primary insured: ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother Other - Please Specify

f) Occupation: ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired Other - Please Specify

g) Address (if different from above)

City State Pin Code

Phone No Email Id

h) Patient Details

SECTION D - DETAILS OF HOSPITALIZATION

a) Name of Hospital where admitted

b) Room Category occupied ☐ Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room

e) Date of Admission d d m m y y y y f) Time H H M M

g) Date of discharge d d m m y y y y h) Time H H M M

j) System of medicine ☐ I) Allopathy ☐ ii) Ayush

SECTION E - DETAILS OF CLAIM

a) Details of treatment expenses claimed

i. Pre hospitalization expenses ₹ ii. hospitalization expenses ₹

iii. Post hospitalization expenses ₹ iv. home care treatment cost ₹

v. Ambulance charges ₹ vii Others(code) ₹

TOTAL ₹

viii. Pre hospitalization period _________________days ix. Post hospitalization period ________________ days

b) Details of Lump sum/cash benefit claimed i. Hospital Daily Cash ₹ _________________/- TOTAL ₹ _____________________________/-

SECTION F - DETAILS OF BILLS ENCLOSED

S.No	Bill No	Date	Issued By	Towards	Amount ₹)
1		d d m m y y y y		Hospital main Bill	
2		d d m m y y y y		Pre hospitalization Bills ____________Nos	
3		d d m m y y y y		Post hospitalization Bills ___________Nos	
4		d d m m y y y y		Home care treatment Bills	
5		d d m m y y y y		Pharmacy Bills	
6		d d m m y y y y		Other expenses if any _______________________	
7					
8					
9					
10					

COVID HOSPITALIZATION COVER- CLAIM DOCUMENT SUBMISSION CHECKLIST

S.No	Documents
1	☐ Duly filled and signed Claim Form
2	☐ Copy of Insured Person's passport, if available (All pages)
3	☐ Photo Identity proof of the patient (if insured person does not own a passport)
4	☐ Medical practitioner's prescription advising admission
5	☐ Original bills with itemized break-up
6	☐ Payment receipts
7	☐ Discharge summary including complete medical history of the patient along with other details.
8	☐ Investigation reports including Insured Person's test reports from Authorized diagnostic centre for COVID
9	☐ OT notes or Surgeon's certificate giving details of the operation performed, wherever applicable
10	☐ Sticker/Invoice of the Implants, wherever applicable.
11	☐ NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
12	☐ KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines
13	☐ Legal heir/succession certificate, wherever applicable

Any other relevant document required by Company for assessment of the claim.

HOME CARE TREATMENT EXPENSES- CLAIM DOCUMENT SUBMISSION CHECKLIST

S.No	Documents
1	☐ Duly filled and signed Claim Form
2	☐ Copy of Insured Person's passport, if available (All pages)
3	☐ Photo Identity proof of the patient (if insured person does not own a passport)
4	☐ Medical practitioners' prescription advising hospitalization
5	☐ A certificate from medical practitioner advising treatment at home or consent from the insured person on availing home care benefit.
6	☐ Discharge Certificate from medical practitioner specifying date of start and completion of home care treatment.
7	☐ Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.

Note:

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

SECTION G - PROPOSER/INSURED BANK DETAILS

1. Name of the Bank Account Holder ☐ Mr. ☐ Mrs. ☐ Ms. F I R S T M I D D L E L A S T
2. Bank Account No.:
3. Account: ☐ Saving ☐ Current ☐ Other
4. Name of the Bank
5. Branch
6. MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)
7. IFSC Code (11 character code appearing on your cheque leaf)

☐ I understand that any refund due on the premium payment / any payment / claims to be directly credited to my aforesaid Bank Account.*

*As per IRDAI, its mandatory that all payments made to the insured are only through electronic mode.

SECTION H - DECLARATION BY THE INSURED

I hereby declare that the information furnished in this claim form is true and correct to the best of my knowledge and belief. If I made any false or untrue statement, suppression or concealment of any material fact with respects to questions asked in relation to the claimed, my right to claim reimbursement shall be forfeited. I also consent & authorize 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 d d m m y y y y Place ________________________ Signature of the Insured __________________________

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