**THE NEW INDIA ASSURANCE CO. LTD.,**

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

**UNIVERSAL HEALTH INSURANCE POLICY for APL FAMILIES**

| Policy issuing office |
|---|
| |

# CLAIM FORM

**(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 treating doctor
Name of Hospital

Date of Admission: Date of Discharge:

Amount:

### B) DISABILITY COMPENSATION:

**Amount:**

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 insured:

Sex Age:

Date of accident: Date of death:

Details of accident in brief:

Date of intimation to Police:
Please submit FIR & Post Mortem Report

---

I declare that to the best of my knowledge all particulars contained in form are true

Date: Signature of the Claimant/Nominee
Place:

---

For Office Use Only:

**SECTION I** **Amount:**

A) Claim under Hospitalisation:
B) Claim for Disability Compensation
C) Claim under Maternity Benefit

**SECTION II**

PA CLAIM FOR DEATH
Total: