Royal Sundaram

MEDICAL EXPENSES CLAIM FORM

FOR OFFICE USE ONLY

Issuing office :_____

Date of Issue :_____

Claim No :_____

ROYAL SUNDARAM ALLIANCE INSURANCE COMPANY LIMITED

46, Whites Road, Chennai-600 014. Telephone : 044-28517387 - 7391 Fax: 044-2851 5500

E-mail : customer.services@royalsundaram.in

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

Please ensure that all questions are answered in capital letters using an ink pen

Policy Number		Certificate Number	
Card Number Account Number		Name of the Bank	

1. INSURANCE DETAILS

Name of the Insured	
Name of the injured person	
Address for Correspondence (with Pin Code)	
Telephone Daytime / Mobile No.	STD Code :
Telephone Evening	STD Code :
E-Mail ID	

2.DETAILS OF THE ACCIDENT

Date of the accident	(DD/MM/YY)
Time of the accident	(AM/PM)
Place of the accident	
Nature and cause of accident	
Was the accident reported to the Police ?	Yes ☐ No ☐
If yes please give the address of the Police Station If no please give reasons why	
First Information Report No.	

3. DETAILS OF INJURY

Nature of injury/disablement (if to limb or eye, please state whether right or left)

Name and Address of the attending physician (with Pin Code)

4. DETAILS OF EXPENSES CLAIMED

Date	Type of Expense Incurred	Amount claimed (Rs.)
	Total	

5. OTHER INSURANCE DETAILS

Does the injured person have any other insurance ? Yes ☐ No ☐

If yes , please give the name and address of the company

Policy No.

Amount Insured for

6. DECLARATION

I hereby declare that the foregoing statements are made by myself and are true in all respects. I have not attempted to conceal from the Company anything with which it ought to be made acquainted. I agree that if I have made or, will make any false or fraudulent statement whatsoever, the Policy shall be void and my right to compensation forfeited.

Signature/thumb impression of the insured

Date / /
(DD/MM/YY)

CERTIFICATE FROM THE EYE WITNESS TO THE ACCIDENT

I hereby certify that I was present when the accident occurred to Miss/Mrs/Mr. _____on _____(DD/MM/YY) in the manner stated overleaf. It was caused by _____

_____

which was* / was not* his/her wilful act and he/she/ was* / was not* under the influence of intoxicating liquor / drugs at the time of accident.

*Strike out which is not applicable

Date : / /
(DD/MM/YY)

Signature / thumb impression

Name

Place

Address

PLEASE CHECK THAT ALL QUESTIONS HAVE BEEN COMPLETED IN FULL & THE FORM SIGNED AND DATED.

Please enclose

- ☐ First Information Report - Photocopy duly attested by the issuing authority
- ☐ Medical certificate forming part of the claim form
- ☐ Admission/Discharge summary issued by hospital authority
- ☐ English translation of vernacular documents
- ☐ All original bills and receipts for treatment claimed for

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