Reliance General Insurance
Anil Dhirubhai Ambani Group

GROUP MEDICLAIM INSURANCE POLICY CLAIM FORM

(Issuance of this form does not imply acceptance of the liability)

PLEASE ANSWER EVERY QUESTION AND FULLY

<table>
<tr><td>1. Name of the Employee and Company name</td><td colspan="4"></td></tr>
<tr><td>2. Policy No.</td><td colspan="4"></td></tr>
<tr><td rowspan="8">3. Address of the Insured</td><td>Plot No/Door No.</td><td></td><td>Building name</td><td></td></tr>
<tr><td>Road</td><td colspan="3"></td></tr>
<tr><td>Area</td><td colspan="3"></td></tr>
<tr><td>City</td><td></td><td>Pin code</td><td></td></tr>
<tr><td>State</td><td colspan="3"></td></tr>
<tr><td>Phone No.</td><td colspan="3"></td></tr>
<tr><td>E-mail Id</td><td colspan="3"></td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>4. a) Name of the insured person (in respect of whom the claim is made)
b) Relationship to the insured
c) Present completed age
d) Date of Joining</td><td colspan="4"></td></tr>
<tr><td>5. Date of injury sustained or disease/illness first detected</td><td colspan="4"></td></tr>
<tr><td>6. a) Name & address of the attending medical practitioner
b) Qualification & telephone no
c) Registration no.</td><td colspan="4"></td></tr>
<tr><td>7. Name & address of the hospital/nursing home/clinic</td><td colspan="4"></td></tr>
<tr><td>8. Date of admission
9. Date of discharge</td><td colspan="4"></td></tr>
</table>

10. If the claim is for domiciliary hospitalisation, please indicate	
a) Date of commencement of treatment	a)
b) Date of completion of treatment	b)
c) Name & address of attending medical practitioner	c)
d) Telephone no.	d)
e) Registration no.	e)

11. Schedule of expenses incurred by the claimant under hospitalisation/domiciliary hospitalisation (to be supported by bills/receipts, cash memos etc.)	
	Expenses incurred in the hospital
Amount Claimed (Claim bill attached)	

I have incurred on the treatment of Disease/Illness/Accident referred to above, the expenses as per the details given by me in the attached claim bill.

In support of the claim, the following documents have to be submitted in original along with the claim bill.

1. Original Bills, Receipt and discharge certificate from the Hospital.
2. Cash Memos from the hospital / Chemist(s), supported by the proper prescription
3. Receipt and reports with a supported by the note from the attending Medical practioner / Surgeon demanding such report & test. (Blood, Pathological, Urine, Scane, MRI etc.)
4. Surgeons certificate stating nature of operation performed and Surgeon's bill and receipt.
5. Attending Doctor's / Consultant's / Specialist's / Anesthetist's bills and receipt and certificate regarding diagnosis
6. Certificate regarding admission and discharge from the Hospital.
7. Patient's History report from the attending Doctors.
8. Certificate from the attending Medical Practitioner / Surgeon that the Patient is fully cured.

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.

Date   Signature of the Insured