RAHEJA QBE GENERAL INSURANCE CO. LTD.

CANCER INSURANCE - CLAIM FORM

Insured's Details

Name: _____

Address: _____

_____

City: _____ Pin Code: _____

Phone No: _____ Mobile: _____ email _____

Policy Details:

Policy No.: _____

Policy Period: From _____ To _____

Claimant's Details

Name _____

e-Mail: _____

Address: _____

_____

City: _____ Pin Code: _____

Phone No: _____ Mobile: _____

Relationship with Insured Person _____

Name of the Insured Person: _____

Sex: ☐ Male ☐ Female Date of Birth: ____/____/____

Occupation: _____

Member: _____

Details of Discovery of Cancer

Nature of Cancer _____

What were the symptoms that required consultation? _____

_____

_____

Date when first symptoms appeared _____

Name of Doctor/Specialist you first consulted _____

Contact details of Dr./Specialist _____

Dr./Specialist's Qualifications and RMP No: _____

Please attach related Investigation Reports.

RAHEJA QBE GENERAL INSURANCE CO. LTD.

Claim Particulars

Name & address of Hospital/Nursing Home _____

_____

_____

Name of treating Doctor/Specialist _____

Date of Admission_____ Date of Discharge _____

Date of Operation _____

Nature of surgery carried out _____

Dates on which treatment taken _____

Please submit supporting Bills, Prescription, Investigation Reports _____

Other Insurances

Details of other Health Insurance Policies : Policy No: _____

Name & Address of Insurance Co Policy issuing office: _____

_____

_____

Sum Insured available _____

Details of Previous Claims if any _____

Declaration

I/We declare that I/We have not withheld any material information and that all statements made above are true to the best of my/our knowledge and belief I/We understand that the claim may be refused if the information given above is untrue, inaccurate or concealed.

Further, I/We, the undersigned, authorize any hospital or other medical-care institution, physician or other medical professional, diagnostic centre/laboratory, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to Raheja QBE or its representative, any and all information with respect to any illness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, or illness is the subject of this claim, and copies of all of that person's hospital or medical records, including information relating to treatment of illness, any or all investigation reports, to determine eligibility for benefit payments under the Policy.

Place

Date Signature of Insured

RAHEJA QBE GENERAL INSURANCE CO. LTD.

Medical Certificate

(To be filled in by the Doctor /Specialist who attended the Patient)

1) Name of Patient	
2) Age	
3) Date of first Consultation or Admission to Hospital / Nursing Home for treatment	
4) Date Cancer first detected	
5) With what complaints was the Patient suffering?	
6) Since when was the Patient suffering these symptoms?	
7) Past medical history of Patient	
8) Is the patient suffering from symptoms for which treatment would have been taken in the normal course?	
9) What course of Treatment did you prescribe?	
10) Will there be a need for Chemotherapy/Radiotherapy?	
11) For what duration will Chemotherapy/Radiotherapy be required?	

Signature of Dr _____ **Signature of Patient:** _____

RMP No: _____ **Date:** _____