

Broad Guidelines for Claim Process

1. Please ensure Claim form is completely filled, signed and **submitted in original**.
2. Please provide at least **two contactable mobile numbers and e-mail id** for further communication related to your claim.
3. Indicative list of claim documents has been provided in the Claim Form under Section E. **Please ensure all the documents are submitted in original for smooth processing of claim.**
4. **Claim processing will be delayed in absence of original documents.**
5. **Claim payments are made only through Online Bank Transfers.** Please submit the Bank Account details along with a cancelled cheque. The bank accounts details need to be mentioned in Section G of the Claim Form.

In addition to above, if the claim amount is more than Rs 1 Lakh then following additional documents are required:

6. Pan Card of the Employee.

Claim documents needs to be send on below address: -

Religare Health Insurance-Claims Department
Vipul Tech Square, Tower C, 3rd Floor, Golf Course Road,
Sec-43, Gurugram - 122009 (Haryana)

Now, track your claim status with ease

ONLINE: Please visit below link and enter your Client ID and Policy Number

www.religarehealthinsurance.com/claim_search.php **Center/Claim Search/Enter Client ID and Policy No.**

SMS: Simply SMS your claim reference number in the message format CLAIM <space> CLAIMNUMBER to 77158-77158

Example: To check claim status of claim reference number 11223344, simply SMS CLAIM 11223344 to 77158-77158

Brief description of the key documents required along with the claim form

1. Indoor Case Papers - This document is prepared by hospital on daily basis which maintains daily doctor notes, nursing notes, patient progress details and having patient condition summary from the date of admission till discharge.
2. Hospital Discharge Summary - Summary of hospitalization period including - Admission date, discharge date, diagnosis, line of treatment given to patient during hospitalization and further advice on discharge.
3. Payment Receipts - Receipts of payment done to hospital authorities towards all bills, investigation reports or any other procedure done.
4. Consultation Papers - Written prescription of the Medical Practitioner with whom patient has consulted.
5. **NEFT (Net Electronic Fund Transfer) – We require original cancelled cheque of the policyholder and relevant details to be mandatorily filled under Sector-G of claim form.**

Terms and Conditions for Payments through RTGS/NEFT

1. The details provided by the policyholder in the mandate form shall be considered as final and Religare Health Insurance Company Limited shall not be responsible for cross verifying of any of the details provided therein.
2. The policy holder agrees that transaction through RTGS/NEFT facility may attract inward RTGS/NEFT charges, which if levied by the policyholder's bank shall be borne by the policy holder only.
3. Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company.
4. I/We further undertake to refund any excess amount whether demanded by Religare Health Insurance Company Limited or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from Religare Health Insurance Company Limited of such excess credit or such information of excess credit coming to the knowledge of the policy holder through any other source.
5. The policyholder agrees that under RTGS/NEFT facility, there may be risk of non-payment in the policyholder accounts number on the day of the credit of payments due to change in the applicable regulations pertaining to RTGS/NEFT facility or due to any other reasons without any fault/inaction/failure on part of Religare Health Insurance Company Limited or any factor beyond the control of Religare Health Insurance Company Limited.

Claim Form - 'CARE'
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.

Claim Intimation No.: _____

Section A - Details of Primary Insured

a) Policy No. :

b) SL No./Certificate No.: c) Company/TPA ID No.:

d) Name :
(Surname) (First Name) (Middle Name)

e) Address :

 City :

State : Pin Code :

Phone Number :

E-mail :

Section B - Details of Insurance History

a) Currently covered by any other Mediciam/Health Insurance : Yes No

b) Date of commencement of first insurance without break : / / (DD/MM/YYYY)

c) If yes, Company Name :
 Policy Number : Sum Insured (Rs.):

d) Have you ever been hospitalized in the last 4 years since inception of the contract? Yes No

- Date : / / (DD/MM/YYYY)
- Diagnosis: _____

e) Previously covered by any other Mediciam/Health Insurance : Yes No

f) If yes, Company Name :

Section C - Details of Insured Person Hospitalised

Title : Mr. Ms.

a) Name :
(Surname) (First Name) (Middle Name)

b) Gender : M F c) Age : / (YY/MM) d) Date of Birth : / /

e) Relationship with Primary Insured : Self Spouse Child Father Mother
 Others (Please Specify) _____

f) Occupation : Service Self Employed Homemaker Retired Student Others (Please Specify) _____

g) Address :
(if different from above)

 City :

State : Pin Code :

h) Phone Number :

i) E-mail :

Section D - Details of Hospitalisation

- a) Name of Hospital where Admitted :
- b) Room Category occupied : Day Care Single Occupancy Twin Sharing 3 or more beds per room
- c) Hospitalisation due to : Injury Illness Maternity
- d) Date of Injury/Date Disease first detected/Date of Delivery : / / (DD/MM/YYYY)
- e) Date of Admission : / / (DD/MM/YYYY) f) Time of Admission : : (HH:MM)
- g) Date of Discharge : / / (DD/MM/YYYY) h) Time of Discharge : : (HH:MM)
- i) If Injury, give cause : Self Inflicted Road Traffic Accident Substance Abuse/Alcohol Consumption
- ii) If Medico Legal : Yes No
- iii) MLC Report & Police FIR attached : Yes No
- ii) Reported to Police : Yes No
- j) System of Medicine : _____

Section E - Details of Claim

- a) Details of the treatment expenses claimed
- (i) Pre-hospitalization Expenses : Rs.
- (ii) Hospitalization Expenses : Rs.
- (iii) Post-hospitalization Expenses : Rs.
- (iv) Health Check-up cost : Rs.
- (v) Ambulance Charges : Rs.
- (vi) Others (code) : Rs.
- Total : Rs.
- (vii) Pre-hospitalization period : days
- (viii) Post-hospitalization period : days
- b) Claim for Domiciliary Hospitalization: Yes No
(If yes, provide details in annexure)
- c) Details of Lump sum/cash benefit claimed:
- (i) Hospital Daily Cash :Rs.
- (ii) Surgical Cash :Rs.
- (iii) Critical Illness Benefit :Rs.
- (iv) Convalescence :Rs.
- (v) Pre/Post hospitalization Lump sum benefit :Rs.
- (vi) Others :Rs.
- Total :Rs.
- d) Claim Documents Submitted - Checklist
- (i) Claim Form Duly signed :
- (ii) Copy of the claim intimation, if any :
- (iii) Hospital Main Bill :
- (iv) Hospital Break-up Bill :
- (v) Hospital Bill Payment Receipt :
- (vi) Hospital Discharge Summary :
- (vii) Pharmacy Bill :
- (viii) Operation Theatre Notes :
- (ix) ECG :
- (x) Doctor's request for investigation :
- (xi) Investigation Reports (Including CT/MRI/USG/HPE) :
- (xii) Doctor's Prescriptions :
- (xiii) Others _____

Section F - Details of Bills Enclosed

| S No. | Bill No. | Date | Issued by | Towards | Amount (INR) |
|-------|----------|--------------|-----------|------------------------------------|--------------|
| 1 | | (DD/MM/YYYY) | | Hospital Main Bill | |
| 2 | | (DD/MM/YYYY) | | Pre-hospitalization Bills: ___Nos | |
| 3 | | (DD/MM/YYYY) | | Post-hospitalization Bills: ___Nos | |
| 4 | | (DD/MM/YYYY) | | Pharmacy bills | |
| 5 | | (DD/MM/YYYY) | | | |
| 6 | | (DD/MM/YYYY) | | | |
| 7 | | (DD/MM/YYYY) | | | |
| 8 | | (DD/MM/YYYY) | | | |
| 9 | | (DD/MM/YYYY) | | | |
| 10 | | (DD/MM/YYYY) | | | |

In case of more details, please attach a separate sheet.

Section G - Details of Primary Insured's Bank Account

a) PAN :

b) Account Number :

c) Bank Name & Branch :

d) Cheque/DD payable details :

e) IFSC Code :

Section H - Declaration by the Insured

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA/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 : / / (DD/MM/YYYY)

Signature of the Insured : _____

Place : _____

Guidance For Filling Claim Form- Part A (To be filled in by the insured)

| Data Element | Description | Format |
|---|---|---|
| Section A - Details of Primary Insured | | |
| a) Policy No. | Enter the policy number | As allotted by the insurance company |
| b) Sl. No/ Certificate No. | Enter the social insurance number or the certificate number of social health insurance scheme | As allotted by the organization |
| c) Company TPA ID No. | Enter the TPA ID No. | License number as allotted by IRDA and printed in TPA documents |
| d) Name | Enter the full name of the policyholder | Surname, First name, Middle name |
| e) Address | Enter the full postal address | Include Street, City and Pin Code |
| Section B - Details of Insurance History | | |
| a) Currently covered by any other Mediciam/Health Insurance? | Indicate whether currently covered by another Mediciam/Health Insurance | Tick Yes or No |
| b) Date of Commencement of first Insurance without break | Enter the date of commencement of first insurance | Use dd-mm-yy format |
| c) Company Name | Enter the full name of the insurance company | Name of the organization in full |
| Policy No. | Enter the policy number | As allotted by the insurance company |
| Sum Insured | Enter the total sum insured as per the policy | In rupees |
| d) Have you been Hospitalised in the last four years since inception of the contract? | Indicate whether hospitalized in the last four years | Tick Yes or No |
| Date | Enter the date of hospitalization | Use mm-yy format |
| Diagnosis | Enter the diagnosis details | Open Text |
| e) Previously Covered by any other Mediciam/Health Insurance? | Indicate whether previously covered by another Mediciam/Health Insurance | Tick Yes or No |
| f) Company Name | Enter the full name of the insurance company | Name of the organization in full |
| Section C - Details of Insured Person Hospitalised | | |
| a) Name | Enter the full name of the patient | Surname, First name, Middle name |
| b) Gender | Indicate Gender of the patient | Tick Male or Female |
| c) Age | Enter age of the patient | Number of years and months |
| d) Date of Birth | Enter Date of Birth of patient | Use dd-mm-yy format |
| e) Relationship with primary Insured | Indicate relationship of patient with policyholder | Tick the right option. If others, please specify |
| f) Occupation | Indicate occupation of patient | Tick the right option. If others, please specify |
| g) Address | Enter the full postal address | Include Street, City and Pin Code |
| h) Landline | Enter the phone number of patient | Include STD code with telephone number |
| i) E-mail ID | Enter e-mail address of patient | Complete e-mail address |
| Section D - Details of Hospitalisation | | |
| a) Name of Hospital where admitted | Enter the name of hospital | Name of hospital in full |
| b) Room category occupied | Indicate the room category occupied | Tick the right option |
| c) Hospitalization due to | Indicate reason of hospitalization | Tick the right option |
| d) Date of Injury/Date Disease first detected/ Date of Delivery | Enter the relevant date | Use dd-mm-yy format |
| e) Date of admission | Enter date of admission | Use dd-mm-yy format |
| f) Time | Enter time of admission | Use hh:mm format |
| g) Date of discharge | Enter date of discharge | Use dd-mm-yy format |
| h) Time | Enter time of discharge | Use hh:mm format |
| i) If Injury give cause | Indicate cause of injury | Tick the right option |
| If Medico legal | Indicate whether injury is medico legal | Tick Yes or No |
| Reported to Police | Indicate whether police report was filed | Tick Yes or No |
| MLC Report & Police FIR attached | Indicate whether MLC report and Police FIR attached | Tick Yes or No |
| j) System of Medicine | Enter the system of medicine followed in treating the patient | Open Text |
| Section E - Details of Claim | | |
| Claim Made for | Select the event for which the claim is made | Tick Yes or No |
| a) Details of Treatment Expenses | Enter the amount claimed as treatment expenses | In rupees (Do not enter paise values) |
| b) Claim for Domiciliary Hospitalization | Indicate whether claim is for domiciliary hospitalization | Tick Yes or No |
| c) Details of Lump sum/cash benefit claimed | Enter the amount claimed as lump sum/cash benefit | In rupees (Do not enter paise values) |
| d) Claim Documents Submitted-Check List | Indicate which supporting documents are submitted | Tick the right option |
| Section F - Details of Bills Enclosed | | |
| Indicate which bills are enclosed with the amounts in rupees | | |

Religare Health Insurance Company Limited

Registered Office: 5th Floor, 19 Chawla House, Nehru Place, New Delhi-110019 Corresp. Office: Vipul Tech Square, Tower C, 3rd Floor, Golf Course Rd, Sec-43, Gurugram-122009 (Haryana).
 Website: www.religarehealthinsurance.com E-mail: customerfirst@religarehealthinsurance.com Call us: 1800-102-4488 | 1860-500-4488
 CIN: U66000DL2007PLC161503 UIN: IRDAI/HLT/RHI/P-H/V.II/253/16-17 IRDA Registration No. - 148

| Data Element | Description | Format |
|---|---|---|
| Section G - Details of Primary Insured's Bank Account | | |
| a) PAN | Enter the permanent account number | As allotted by the Income Tax department |
| b) Account Number | Enter the bank account number | As allotted by the bank |
| c) Bank Name and Branch | Enter the bank name along with the branch | Name of the Bank in full |
| d) Cheque/DD payable details | Enter the name of the beneficiary the cheque/DD should be made out to | Name of the individual/organization in full |
| e) IFSC Code | Enter the IFSC code of the bank branch | IFSC code of the bank branch in full |
| Section H - Declaration by the Insured | | |
| Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. | | |

Claim Form - 'CARE'

Part B

1. To be filled in by the hospital.
2. The issue of this Form is not to be taken as an admission of liability.
3. Please include the original pre-authorization request form in lieu of PART A.
4. To be filled in block letters.

Section A - Details of Hospital

a) Name of the Hospital :

b) Hospital ID :

c) Type of Hospital : Network Non-network (if non-network fill section E)

d) Name of the treating doctor : (Surname) (First Name) (Middle Name)

e) Qualification :

f) Registration No. with State Code :

g) Contact No. :

Section B - Details of the Patient Admitted

a) Name of the Patient: (Surname) (First Name) (Middle Name)

b) IP Registration No. :

c) Gender : M F d) Age : / (YY/MM) e) Date of Birth : / /

f) Date of Admission : / / (DD/MM/YYYY) g) Time of Admission : : (HH:MM)

h) Date of Discharge : / / (DD/MM/YYYY) i) Time of Discharge : : (HH:MM)

j) Type of Admission : Emergency Planned Day Care Maternity

k) If Maternity,
(i) Date of Delivery : / / (DD/MM/YYYY) (ii) Gravida Status : _____

l) Status at the time of discharge : Discharge to home Discharge to another hospital Deceased

m) Total Claimed Amount :

Section C - Details of Ailment Diagnosed (Primary)

a) (i) Primary Diagnosis : ICD I0 Code : Description : _____
(ii) Additional Diagnosis : ICD I0 Code : Description : _____
(iii) Co-morbidities : ICD I0 Code : Description : _____
(iv) Co-morbidities : ICD I0 Code : Description : _____

b) (i) Procedure 1 : ICD I0 Code : Description : _____
(ii) Procedure 2 : ICD I0 Code : Description : _____
(iii) Procedure 3 : ICD I0 Code : Description : _____
(iv) Details of Procedure : _____

c) Present ailment is a complication of PED: Yes No
If yes, specify details : _____

d) Pre-authorization obtained : Yes No

e) Pre-authorization no. :

f) If authorization by network hospital not obtained, give reason : _____

- g) Hospitalization due to Injury : Yes No
- (i) If yes, give cause : Self inflicted Road Traffic Accident Substance Abuse/Alcohol Consumption
- (ii) If Injury due to Substance abuse/Alcohol consumption, Test conducted to establish this : Yes No
(If yes, attach reports)
- (iii) If Medico Legal : Yes No
- (iv) Reported to Police : Yes No
- (v) FIR No. :
- (vi) If not reported to Police, give reason : _____

Section D - Claim Documents Submitted - Checklist

- | | | | |
|--|----------------------------|---|----------------------------|
| (i) Duly signed Claim Form | : <input type="checkbox"/> | (ix) Investigation Report | : <input type="checkbox"/> |
| (ii) Original Pre-authorization request | : <input type="checkbox"/> | (x) CT/MRI/USG/HPE investigation reports | : <input type="checkbox"/> |
| (iii) Copy of Pre-authorization approval letter | : <input type="checkbox"/> | (xi) Doctor's reference slip for investigation | : <input type="checkbox"/> |
| (iv) Copy of photo ID card of patient verified by hospital | : <input type="checkbox"/> | (xii) ECG | : <input type="checkbox"/> |
| (v) Hospital Discharge Summary | : <input type="checkbox"/> | (xiii) Pharmacy Bills | : <input type="checkbox"/> |
| (vi) Operation Theatre notes | : <input type="checkbox"/> | (xiv) MLC report & Police FIR | : <input type="checkbox"/> |
| (vii) Hospital Main Bill | : <input type="checkbox"/> | (xv) Original death summary from hospital where applicable: | <input type="checkbox"/> |
| (viii) Hospital Break-up Bill | : <input type="checkbox"/> | (xvi) Any other, please specify _____: | <input type="checkbox"/> |

Section E - Additional Details in case of Non-Network Hospital (Only fill in case of non-network hospital)

- a) Address of the Hospital :
- City :
- State : Pin Code :
- b) Contact No. : -
- c) Registration No. with State Code :
- d) Hospital PAN :
- e) No. of inpatient beds :
- f) Facilities available in the hospital : (i) OT: Yes No (ii) ICU: Yes No
- (iii) Others: _____

Section F - Declaration by the Hospital

(Please read very carefully)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material facts, our right to claim under this claim shall be forfeited.

Date : / / (DD/MM/YYYY)

Signature & Seal of the Hospital Authority : _____

Place : _____

Guidance For Filling Claim Form- Part B (To be filled in by the hospital)

| Data Element | Description | Format |
|--|---|--|
| Section A - Details of Hospital | | |
| a) Name of Hospital | Enter the name of hospital | Name of hospital in full |
| b) Hospital ID | Enter ID number of hospital | As allocated by the TPA |
| c) Type of Hospital | Indicate whether In network or non-network hospital | Tick the right option |
| d) Name of treating doctor | Name of treating doctor | Name of doctor in full |
| e) Qualification | Enter the qualifications of the treating doctor | Abbreviations of educational qualifications |
| f) Registration No. with State Code | Enter the registration number of the doctor along with the state Code | As allocated by the Medical Council of India |
| g) Contact No. | Enter the phone number of doctor | Include STD code with telephone number |
| Section B - Details of Patient Admitted | | |
| a) Name of Patient | Enter the name of hospital | Name of hospital in full |
| b) IP Registration Number | Enter insurance provider registration number | As allotted by the insurance provider |
| c) Gender | Indicate Gender of the patient | Tick Male or Female |
| d) Age | Enter age of the patient | Number of years and months |
| e) Date of Birth | Enter Date of Birth of patient | Use dd-mm-yy format |
| f) Date of admission | Enter date of admission | Use dd-mm-yy format |
| g) Time | Enter time of admission | Use hh:mm format |
| h) Date of discharge | Enter date of discharge | Use dd-mm-yy format |
| i) Time | Enter time of discharge | Use hh:mm format |
| j) Type of Admission | Indicate type of admission of patient | Tick the right option |
| k) If Maternity | | |
| Date of Delivery | Enter Date of Delivery if maternity | Use dd-mm-yy format |
| Gravida Status | Enter Gravida status if maternity | Use standard format |
| l) Status at time of discharge | Indicate status of patient at time of discharge | Tick the right option |
| m) Total claimed amount | Indicate the total claimed amount | In rupees (Do not enter paise values) |
| Section C - Details of Ailment Diagnosed (Primary) | | |
| a) ICD 10 Code | | |
| Primary Diagnosis | Enter the ICD 10 Code and description of the primary Diagnosis | Standard Format and Open text |
| Additional Diagnosis | Enter the ICD 10 Code and description of the additional Diagnosis | Standard Format and Open text |
| Co-morbidities | Enter the ICD 10 Code and description of the co-morbidities | Standard Format and Open text |
| b) ICD 10 PCS | | |
| Procedure 1 | Enter the ICD 10 PCS and description of the first procedure | Standard Format and Open text |
| Procedure 2 | Enter the ICD 10 PCS and description of the second procedure | Standard Format and Open text |
| Procedure 3 | Enter the ICD 10 PCS and description of the third procedure | Standard Format and Open text |
| Details of Procedure | Enter the details of the procedure | Open text |
| c) PED | Indicate whether present ailment is a combination of PED | Tick Yes or No |
| If yes, specify details | Enter the details of PED | Open text |
| d) Pre-authorization obtained | Indicate whether pre-authorization obtained | Tick Yes or No |
| e) Pre-authorization Number | Enter pre-authorization number | As allotted by TPA |
| f) If authorization by network hospital not obtained, give reason | Enter reason for not obtaining pre-authorization number | Open text |
| g) Hospitalization due to injury | Indicate if hospitalization is due to injury | Tick Yes or No |
| Cause | Indicate cause of injury | Tick the right option |
| If injury due to substance abuse/alcohol consumption, test conducted to establish this | Indicate whether test conducted | Tick Yes or No |
| If Medico Legal | Indicate whether injury is medico legal | Tick Yes or No |
| Reported To Police | Indicate whether police report was filed | Tick Yes or No |
| FIR No. | Enter first information report number | As issued by police authorities |
| If not reported to police, give reason | Enter reason for not reporting to police | Open text |
| Section D - Claims Document Submitted Checklist | | |
| Indicate which supporting documents are submitted | | |

| Data Element | Description | Format |
|--|---|--|
| Section E - Additional Details in case of Non-Network Hospital | | |
| a) Address | Enter the full postal address | Include Street, City and Pin Code |
| b) Contact No. | Enter the phone number of hospital | Include STD code with telephone number |
| c) Registration No. with State Code | Enter the registration number of the doctor along with the state Code | As allocated by the Medical Council of India |
| d) Hospital PAN | Enter the permanent account number | As allotted by the Income Tax department |
| e) Number of Inpatient beds | Enter the number of inpatient beds | Digits |
| f) Facilities available in the hospital | Indicate facilities available in the hospital | Tick the right option. If others, please specify |
| Section F - Declaration by the Hospital | | |
| Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp | | |

Annexure – I to Claim Form

If a claim is made for any of the following Benefits under 'Travel Plus', then kindly tick the appropriate Benefit and fill in the corresponding details:-

Worldwide In-Patient Cover (for emergency) :

Worldwide OPD Cover :

Note: If claiming under 'Worldwide OPD Cover', only the relevant fields need to be filled.

Name, address and telephone number of Hospital where treatment was given: _____

Name of treating Medical Practitioner: _____

Details of Illness/Injury: _____

Cause of the Illness/Injury: _____

Was the Illness/incident caused/ aggravated due to a pre-existing condition? Please give details: _____

Date of onset of Illness (DDMMYYYY): _____

Nature of treatment: _____

Date of treatment (DDMMYYYY): From To

Loss of Passport

Date of loss (DDMMYYYY): Place of loss: _____

Detail / Circumstances of loss: _____

Total expenses: _____

Loss of Checked-in Baggage

Name of Common Carrier: _____

Date of loss (DDMMYYYY): Place of loss: _____

Port of disembarkation: _____

| Serial no. | Details of Loss | Amount |
|------------|-----------------|--------|
| | | |
| | | |
| | | |

Repatriation of Mortal Remains

Cause of death: _____

Date of death of Insured (DDMMYYYY): Total expenses: _____

Transportation From: _____ To: _____ Date:

Medical Evacuation

If Medical Evacuation is done, reason for Medical Evacuation: _____

Medical Evacuation From: _____ To: _____ Date:

| Serial no. | Expense Details | Amount |
|------------|-----------------|--------|
| | | |
| | | |
| | | |

Consent Letter

Date

To,

The Medical Superintendent

Dear Sir,

Re : Authorization in favour of M/s Religare Health Insurance Company Limited and its authorized agents.

I have undergone treatment for

_____ from _____ to _____ in your hospital under Inpatient No _____.

I hereby authorise M/s Religare Health Insurance Company Limited and/or its authorised representative to seek any medical information / records from you or from the Medical Practitioners who has attended on me in connection with the above ailment.

I have no objection in case they seek such information/records in whatsoever regards.

Thanking You,

Yours Faithfully

(Signature of the Claimant)

Address of the Insured -