FAMILY BENEFIT SCHEME OF PPLSSS OF IMA TAMILNADU

Issuance of this form does not amount to admission of any liability under the claim of the part of Scheme.

Please give the following information correctly to enable the Scheme to process your claim promptly.

1. Name of the Member :
   (in whose name subscription paid)

2. Details of the claim person :
   (in respect of whom is made)
   a) Name & Relationship to the member
   b) Residential address with Phone No

3. Scheme of Membership No :

4. Nature of Diseases/Illness contracted or injury sustained :

5. Date of injury sustained/diseases/Illness First detected :

6. a) Name of Address of the attending Medical Practitioner :

   b)Qualification & Telephone No.

   c) Registration No.

7. a) Name & Address of the Hospital/Nursing Home/Clinic :

   b) Date of Admission:
   c) Date of Discharge :

8. If the claim for the Domiciliary hospitalization please indicate:
   a) Date of Commencement of treatment
   b) Date of completion of treatment
   c) Name of Address of attending Medical Practitioner
   d) Telephone No.
   e) Registration No.
9. Amount of claims preferred if any under this Scheme earlier.

I have incurred on the treatment of Diseases/illness/Accident referred to above, the expenses as per the details given by me in the Schedule of Expenses given below:

In support of the above claim, I enclose following documents, please indicate by

1. Bill receipt and Discharge certificate/card from the Hospital
2. Cash memos from the Hospital/Chemist (S) supported by the proper prescription.
3. Receipt and pathologist test reports from a pathologist supported by the note from the attending medical practitioner/surgeon demanding such pathologist test.
4. Surgeons certificate stating nature of operation performed and surgeon's bill and receipt.
5. Attending doctor's/consultant's/specialists/Anesthetist's bill and receipt and certificate regarding diagnosis.
6. In case of Domiciliary hospitalization, receipt from a qualified nurse who attended the patient at his/her residence duly supported by a certificate from attending medical practitioner.
7. Certificate from the attending Medical Practitioner giving reasons for allowing treatment at home.

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if 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 is respect of the above treatment, no benefits are admissible under any other medical scheme or insurance.

Dated at…… This……. Day of……..200

SIGNATURE OF THE MEMBER SIGNATURE OF THE CLAIMANT

SCHEDULE OF EXPENSES INCURRED BY THE CLAIMANT

DETAILS OF EXPENSES CLAIMED

Cl.No.Bill Reference Nature of Expenditure Amt. Claimed(Rs.)

Place:
Date: Signature of the Claimant

FOR OFFICE USE ONLY

Total Claim approved for Rs……

Sum Assured ……

Claims already paid …….

Balance available ……..

Secretary

TO BE COMPLETED BY THE ATTENDING DOCTOR & HOSPITAL

1. Name of the Patient :

2. Age :

3. Date of Admission :
   Date of Operation :
   Date of Discharge :

4. Surgeons :

5. Diagnosis :

6. Past History of the Patient :

7. With what Complaints was
   The Patient got admitted :

8. Since when was the Patient
   Suffering from the said Complaints :

9. Investigations :

10. Reports :

11. Operative Notes :

12. Treatment given :

13. Advise/Recommendations :

SIGNATURE & SEAL OF THE DOCTOR

SEAL OF THE HOSPITAL

Promoted by Local Branch President/Secretary

Signature with Branch Seal