UNITED INDIA INSURANCE CO. LTD.,
(A subsidiary of General Insurance Corporation of India)
Regd. & Head Office: United India House, 24, Whites Road, Chennai 600 014.

DOMICILIARY HOSPITALIZATION CLAIM FORM

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

Please give the following information correctly and completely to enable the Company to process your claim promptly.

1	Name of the Insured (in whose name policy is issued)		:	
2	Details of the Insured person (in respect of whom claim is made)		:	
	(a)	Name & relationship to the Insured	:	
	(b)	Present completed age	:	
	©	Occupation	:	
	(d)	Residential address	:	
3	Policy no.		:	
4	Nature of disease/illness contracted or injury suffered		:	
5	Date of injury sustained or Diseases/illness first detected		:	Date Month Year
6	(a)	Name & address of the attending Medical Practitioner	:	
	(b)	Registration no.	:	
	©	Qualification & Tel. no.	:	
7	(a)	Name & address of the Hospital/Nursing Home	:	
	(b)	Registration no.	:	
	©	Date of Admission	:	Date Month Year
	(d)	Date of Discharge	:	Date Month Year
8	If the claim is for Domiciliary Hospitalizations, please indicate			
	(a)	Date of commencement of treatment	:	Date Month Year
	(b)	Date of completion of treatment	:	Date Month Year
	©	Name & Address of attending Medical Practitioner	:	

	(d)	Telephone no.	:	
	(e)	Registration no.	:	

I have incurred on the treatment of Disease/illness/accident referred of above, the expenses as per the _____ given by me in the Schedule of Expenses given overleaf.

I hereby warrant the truth of foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statements, 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.

Dated at _____ this _____ day of _____ 20

Signature of the Claimant

SCHEDULE OF EXPENSES INCURRED AND BEING CLAIMED BY THE CLAIMANT

Sr. No.	Receipt		Nature of Expenditure	Amt. claimed (`)	Amt. payable (`)
	No.	Date			

- **Discharge Card incorporating detailed Discharge Summary and Case History is mandatory to be submitted separately with the Claim Form.**

Signature of the Insured Person

W.E.F. 16/08/2011, all Health claims will be paid through ELECTRONIC TRANSFER (NEFT/RTGS), hence it is mandatory to give following details to TPA :

1	Name of the Account holder	:	
2	Bank name	:	
3	Full Bank Account no. (without /,- or any special characters)	:	
4	IFSC code	:	
5	Account type (savings/current)	:	
6	Bank address	:	
7	Mobile number	:	
8	E-mail ID	:	

Attach copy of cancelled cheque leaf to ensure accuracy of details provided.

CERTIFICATE OF NON-REMARRIAGE

I hereby declare that I have not remarried after the death of my husband Sri _____ _____ who was an employee/Pensioner of your bank. I undertake to inform the bank in case of my re-marriage.

Place :

Date : **Signature / T.I. of the Pensioner**

NON-RE EMPLOYMENT CERTIFICATE

I hereby declare / certify that I have not accepted any commercial employment after my retirement till this date.

Further I undertake to obtain prior permission from State Bank of Hyderabad before accepting any commercial employment in future.

Place :

Date : **Signature / T.I. of the Pensioner**

LIFE CERTIFICATE

Certified that I have seen Sri / Smt. _____ Ex _____ (Last Designation) Pensioner under State Bank of Hyderabad (Employees') Pension Regulations 1995 and that he / she is alive on this date.

Signature / T.I. of the Pensioner

P. F. No. :

Signature / T.I. made in my presence

Place :

Date :

Branch Manager / Gazetted Officer

Domiciliary Hospitalization / Domiciliary Treatment

Sr. No.	Treatments
1	Cancer
2	Leukemia
3	Thalassemia
4	Tuberculosis
5	Paralysis
6	Cardiac Ailments
7	Pleurisy
8	Leprosy
9	Kidney Ailment
10	All Seizure disorders
11	Parkinson's diseases
12	Psychiatric disorder including schizophrenia and psychotherapy
13	Diabetes and its complications
14	Hypertension
15	Hepatitis –B
16	Hepatitis - C
17	Hemophilia
18	Myasthenia gravis
19	Wilson's disease
20	Ulcerative Colitis
21	Epidermolysis bullosa
22	Venous Thrombosis(not caused by smoking) Aplastic Anaemia
23	Psoriasis
24	Third Degree burns
25	Arthritis
26	Hypothyroidism
27	Hyperthyroidism expenses incurred on radiotherapy and chemotherapy in the treatment of cancer and leukemia
28	Glaucoma
29	Tumor
30	Diptheria
31	Malaria
32	Non-Alcoholic Cirrhosis of Liver
33	Purpura
34	Typhoid
35	Accidents of Serious Nature
36	Cerebral Palsy
37	Polio
38	All Strokes Leading to Paralysis
39	Haemorrhages caused by accidents
40	All animal/reptile/insect bite or sting
41	Chronic pancreatitis
42	Immuno suppressants

Domiciliary Hospitalization / Domiciliary Treatment

Sr. No.	Treatments
43	Multiple sclerosis / motorneuron disease
44	Status asthamaticus
45	Sequalea of meningitis
46	Osteoporosis
47	Muscular dystrophies
48	Sleep apnea syndrome(not related to obesity)
49	Any organ related (chronic) condition
50	Sickle cell disease
51	Systemic lupus erythematous (SLE)
52	Any connective tissue disorder
53	Varicose veins
54	Thrombo embolism venous thrombosis/venous thrombo embolism (VTE)]
55	Growth disorders
56	Graves' disease
57	Chronic Pulmonary Disease
58	Chronic Bronchitis
59	Physiotherapy and swine flu shall be considered for reimbursement under domiciliary treatment.