IIISLA BENEVOLENT FUND (IBF)

Regd. Office: #6-1-73, Flat No.104 & 106, First Floor, Saeed Plaza, Lakdikapul, Hyderabad – 500004 E-mail: admin@iiisla.co.in, Web-Site: www.iiisla.co.in., Telephone Numbers: 040- 23261072/23261073

CLAIM FORM

Submission of this form does not amount to admission of any liability under the IBF on the part of IIISLA

Please give the following information correctly and completely to enable us to process your claim

To be submitted within a fortnight from the date of discharge from the hospital/death on the above address by registered/speed post or by courier with complete enclosures:

1	Name of member					
	Address of correspondence:					
	IIISLA membership No.			Surveyor's license No.		
	Contact No.					
2	I am suffering from under mentioned critical disease (tick whichever is applicable)					
	A. Lever Cirrhosis		B. Cancer		C. Kidney transplant	
	D. Liver transplant		E. Heart bypass surgery		F.	
3	a. Need reimbursement for the treatment undergone					
	b. Need advance payment to the hospital for the treatment					
	(In case advance payment required submit the estimate of treatment from the hospital and the title in whose name cheque is to be prepared)					
4	Are you at present covered under any other similar type of scheme like health insurance policy or policy for critical diseases? If yes, please give the particulars of each					
	A. Type of coverage			B. Policy No.		
	C. Sum Insured		In words			
5	a. Date of Admission			b. Date of discharge		
	c. Date of death			(only natural/suicidal death is covered)		
6	In support of the above claim, I enclose the following original documents for critical ailment (Please indicate by ticking)					
	i	Bill, Receipt and Discharge certificate / card from the Hospital.				
	ii	Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.				
	iii	Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests.				
	iv	Surgeon's certificate stating nature of operation performed and Surgeon's bill and receipt.				
	v	Attending Doctor's / Consultant's / Specialist's / Anaesthetist's bill and receipt, and				
	vi	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				
	vii	Certificate from attending Medical Practitioner giving reasons for allowing treatment at hom				
	viii	Certificate from attending Medical Practitioner / Surgeon that the patient is fully cured.				

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7	In support of the above claim, I enclose the following original/notarized documents for natural/suicidal death claim. (Pease indicate by ticking)	
	i	Death certificate issued by Doctor
	ii	Death certificate issued by competent Authority of Government.
	iii	Post mortem report
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.		

Signatures of claimant/ Nominee

Relation with member

Date:

Contact No.

Note: For prompt reimbursement of claim all document should be certified by Unit Coordinator/Unit Deputy Coordinator and Chapter Chairman/Chapter Secretary with their Sign and Seal.