



NEPAL INSURANCE COMPANY LTD.

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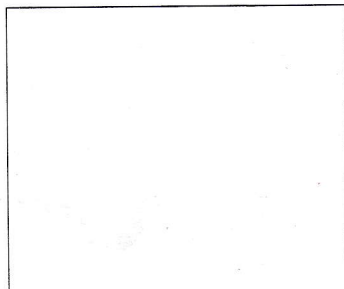
HOSPITALIZATION/DOMICILIARY

CLAIM FORM

Issue of this form does not constitute admission of liability. Please return this form duly completed.

Insured Name :		
Policy No :		
Period of Insurance :		
Name of Staff :		Department :
Designation :		Age :
Dependent's Name :		Age : Relation :
Detail of illness :		
Name of attending Doctor :		Date :
Name of Hospital :		Diagnosis :
Particulars	Claim Amount	For Insurance Company use only.
1. Doctor Fee / Room Rent		
2. Pathology Charge/ Diagnostic materials/ Medicine/ X-ray/ Dialysis/ Chemotherapy/ Radiotherapy		
3. Medicine / Drugs/ Injection / Surgical Appliances/ Artificial Limbs		
4. Anesthesia/ Operation Theatre charge/ Surgeon's charge for operation/ Blood /Oxygen		
Total		

We declare that our member has suffered the above described injuries/ illness and that to the best of our knowledge and belief the foregoing particulars are in every respect true. We also declare that there is no insurance or other source to cover the items claimed.



Company Stamp

Signature of Personnel Manager
(On behalf of the Insured)

Signature of Claimant