



NEPAL INSURANCE COMPANY LTD.

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HEALTH INSURANCE CLAIM FORM

Claim under Health Insurance Scheme:

Claim No.: Policy No.:

1. **MEMBER:** **SR. No.:**
Name: Date of Birth:
Home Address: Office Address:
Designation/Relationship of Employee: Sex:

2. **IF INJURED IN ACCIDENT:**
Date and Time of Accident:
Place of Accident:
Cause of Accident:

3. **IF AN ILLNESS:**
Details of illness:
Date of Incapacity or Diagnosis:

4. **MEDICAL ATTENDANTS:**
Name & Address of Private Doctor:
Attending Member:
Name & Address of all Surgeons, Anesthetists
Specialists, Pathologists, Attending Member:
Name & Address of Member's
Ordinary Medical Attendant:

5. **DETAILS OF CLAIM:**
PLEASE FILL UP the items under which the benefits are claimed in respect of the above illness/accident giving amount claimed and enclosing receipt bills, prescriptions and have the certificate completed by the doctor giving the medical attention in respect of which a claim as made.

Benefit No.	Description of Treatment Received	Cost of Treatment
A	Surgeons and/or Anesthetist Fees	
B	Specialist and/or Pathologist Fees	
C	Charges for Nurse Cabin etc.	
D	Charge for X-ray and/or Electric and/or Massage	
E	Cost of any Surgical Appliances	
F	Cost of Medicines and Drugs	
G	Private Doctor's Fees (Ayurvedic/Home Pathologist)	
H	Charges for Acupuncture	

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

Date:

Signature of Claimant:

Name of the Employee Concerned

Medical certificate to be completed by member's doctor:

I certify that was ill/injured.

Signature: