SHIKHAR INSURANCE COMPANY LTD.

Head Office : Shikhar Biz Centre, Thapathali, P. O. Box No. : 10692, Kathmandu, Nepal.
Tel : 4246101,4246102; Fax :977-1-4246103, E-mail : shikharins@mos.com.np

HEALTH - DOMICILIARY CLAIM FORM (To Be Filled Insured)

Insured Name : ________________________ Designation ________________________

Policy No. ________________________ Policy Period, from __________ to __________

This form is issued without admission of liability and should be completed and returned to Shikhar Insurance Company Ltd., Kathmandu as soon as possible and in any event within 30 days of the commencement/completion of the illness or the date of the accident.

1. MEMBER

Name of the patient ________________________ Date of birth ______________ Age ____

Residential Address________________________ Office Address________________________

Relationship to Employee (if Applicable)________________________ Sex ____

2. If an illness/Diseases

Details of illness/disease -
____

Date of diagnosis ____

3. Medical Attendants	
a.) Name of Medical Institution	
b.) Name and address of Private Doctor Attending Member	
c.) Name & address of all Surgeons, Anesthetists, Specialists, Pathologists attending Member	
d.) Name & address of Member's ordinary medical attendant	
e.) Duration of treatment	

4. Details of Claim

Please fill up items under which the benefits are claimed in respect of the above illness/accident amount claimed and enclosing original receipt, bills, prescriptions and have the certificate completed by the Doctor giving the medical attention in respect of which a claim is made:

S N	Description of treatment received	Cost of treatment
A	Medical Practioners, Consultants & Specialists fee for Consultations/Visits	
B	Diagnostic Materials, Medicines, Drugs and X-ray	
C	Anaesthesia, Blood, Oxygen, Operation Theatre, Surgical Appliances	
D	Room Charges, Board and Nursing Attendance	
E	Other Costs	
	Total	

I declare that I have / my dependent has suffered the above 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.

Signature of Claimant ... ...

Date . . . .

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