NIC
NATIONAL INSURANCE COMPANY
General Insurance

Health Claim Form

IMPORTANT NOTE:

1. Please ensure that **ALL sections** of the claim form are **completed and duly signed.** Incomplete forms may result in delays in the settlement of your claim. All valid claims should be submitted to **NIC General Insurance Co. Ltd, NIC Centre, 217 Royal Road, Curepipe** within a maximum of **1 month** of receiving treatment, failing which the claim will not be processed. It is mandatory that the **claim form be accompanied by the following ORIGINAL documents: invoices, payment receipts, medical reports specifying diagnosis and, prescriptions as applicable from a registered medical practitioner.**
2. Please complete a new/separate claim form for (i) Each Claimant (ii) Each medical condition.
3. Submission of this form to the insurer does not amount to admission of any liability by the insurer.
4. All claim payments will be done by bank transfer to the **policyholder for individual policies** or the **main insured for group policies**.
5. NIC General Insurance Co. Ltd is committed to protecting the confidentiality of the personal information that it collects, uses, retains and discloses in the course of conducting business.

	MAIN INSURED	CLAIMANT (if different from main insured)
Policy Holder /Company		
Surname		
Other Names		
ID Card No.		
Member ID		
Age		
Profession/Occupation		
Mobile/Home /Office No.*		
Address*		
Email*		
Relationship to Main Insured (Spouse, Child, etc.)	NOT APPLICABLE	

BANK ACCOUNT DETAILS OF THE MAIN INSURED ONLY

BANK NAME*	BANK ACCOUNT NAME*	BANK ACCOUNT NUMBER*

* We will use your personal information/contact details submitted to us for the first time on your proposal or claim form. For any changes, please email us on generalinsurance@nicl.mu

Amount Claimed ☐ Illness ☐ Accident (Please tick as appropriate)

Specify nature if illness or details of injury /accident

Other insurance policy information Does the claimant have another health insurance policy? ☐ Yes ☐ No

If yes, Insurer's Name

I hereby declare and affirm that the above statements, particulars, bills, reports and receipts provided as expenses in respect of treatments as per the details given are true and correct. If any of the above statements, particulars, bills, reports and receipts are false or misleading in whole or in part, I agree and understand that the Company shall repudiate my claim(s) arising hereunder and this may lead to the cancellation of the policy and I may be liable for legal action. I hereby give my consent for the Company to seek any information or clarification from the above Hospital/attending doctor/s, consultant/s and specialist/s on the treatments or illnesses or diseases or injuries in respect of the above claim and/or for any other related matter. I also authorise the release of any medical or other information necessary to process this claim. I further agree to have a counter medical examination by a doctor nominated by the Company if the circumstances so required to prove a particular claim.

Date & Signature of the Main Insured

FOR OFFICE USE ONLY	
Claim No. :	
Dt:	
St:	
CH:	
Rsn/ MD:	