भारतीय जीवन बीमा निगम
Life Insurance Corporation of India

Claim form for Domiciliary Treatment Benefit

(Applicable for reimbursement of medical expenses as DTB under Health Insurance plan 901 and 902)

: **For Branch Use only**

Date of Receipt of claim forms:

Signature of the person authorized to receive the documents

TO
The Manager, LIC of India, Divisional Office,

_____

Policy Number:_____ Name of the Principal Insured:_____

Please reimburse Rs. _____ being the medical expenses incurred as Domiciliary Treatment Benefit available under the policy as detailed below:

Details of the Domiciliary Treatment expenses incurred:

Sl.No	Name of the insured persons for whom the claim is made	Status of Insured (PI/Spouse/Child)	Type of treatment (Allopathic, Ayurvedic, etc)	Type of Receipt (Consultation fee, Medicines, Reports, etc)	Receipt/bill Issued by	Bill/Receipt etc, No	date	Amount Rs.
1								
2								
3								
4								
5								
6								
TOTAL								

I hereby declare that,

1. All the insured persons mentioned in this claim form are covered under the policy on the date of the claim
2. The dates of the bills/receipts, etc are within one year from the date of this claim.
3. The total claim amount is more than Rs. 2500 (not applicable during the last year of the policy term)

Encl: All the receipts, bills etc. referred above

Place:

Date: Signature of the Principal Insured/policyholder

Address: _____

_____

Note: DTB claims are payable only two times in a policy year