

# The Federation of Obstetric & Gynaecological Societies of India



Model Residency CHS, 605, Bapurao Jagtap Marg, Jacob Circle, Mahalaxmi (East), Mumbai - 400 011.  
Tel. : +91 22 32954564 / 2302 1648, 2302 1654, 2302 1343\* Fax : +91 22 2301 1383  
Email : fogsibom7.vsnl.net.in / fogsibom2007@gmail.com \* Web : www.fogsibom.org



**PRESIDENT : Dr. Sanjay Gupte,**

Gupte Hospital, 904, Off Bhandarkar Road, Pune - 411 004, India

Tel. : R : +91 20 25656073 C : +91 20 25650785, 25653684 Fax : +91 20 25661237

Mobile : 09822030238 E-mail : guptehospital@gmail.com, guptehospital@rediffmail.com

**Dr. Rishma Dhillon Pai**

**Vice President**

4/11, Avanti Apartments, Senapati Bapat Road, Dadar, Mumbai - 400 028.

Tel : 022 24300885, 24300780, 24370702

Mobile : 9821016005

E-mail : rishmapai@hotmail.com

**Dr. Jaideep Malhotra**

**Vice President**

Malhotra Nursing & Maternity Home (P) Ltd., 84, Mahatma Gandhi Road, Agra - 282 010.

Tel : 0562 260275, 260276, 260279 (R)

Fax : 0562 265194

E-mail : mnmhagra1@gmail.com

mnmhagra@sanchamail.in

**Dr. P. K. Sekharan**

**Vice President**

"Dwarka", State Bank Officer's Colony, Chevayur, Calicut - 673 017.

Tel : 0495 2352954

Fax & Resi : 0495 2356954

Mobile : 09447156954

E-mail : drsekharanpk@hotmail.com

**Dr. Tushar Kar**

**Vice President**

Qr. No. JO -1, S.C.B. Medical College, Hospital Campus, Cuttack, Orissa - 753 001.

Tel : 0671 2415534 Mobile : 9437034520

E-mail : drtusharkar@yahoo.co.in

**Dr. C. N. Purandare**

**Immediate Past President**

Purandare Griha, 31/C, Dr. N. A. Purandare Marg, Mumbai - 400 007.

Tel : 022 23618879 (H) 23641004 (R)

Fax : 022 23021383

Mobile : 9323803663 / 9820088183

E-mail : dr.c.n.purandare@gmail.com

**Dr. P. K. Shah**

**Secretary General**

121, Vithalwadi, 3<sup>rd</sup> floor, Kalbadevi Road, Mumbai - 400 002.

Tel. : 022 22431423 (R) Fax : 022 22411752

Mobile : 9323803665/ 9322234814

E-mail : ifumb@bom5.vsnl.net.in

**Dr. Nozer Sheriar**

**Deputy Secretary General**

15<sup>th</sup> Summer Breeze, 15<sup>th</sup> Road, Bandra (West), Mumbai - 400 050.

Tel : 022 23620862, 26008740 (C)

Fax : 022 26051982

Mobile : 9821097536 / 9323803662

E-mail : sheriar@bom7.vsnl.net.in

**Dr. H. D. Pai**

**Treasurer**

11th Floor, Avanti, Senapati Bapat Marg, Opp. Dadar Western Railway Station, Mumbai - 400028.

Tel : 022 24300780, 24382207, 26438280 (Dir)

Fax : 022 24370702 Mobile : 9820057722

E-mail : hdpai@hotmail.com

**Dr. Girija Wagh**

**Jt. Secretary**

Chaitnya, 6, Sangita Soc., Karve Nagar, Pune - 411 052.

Tel : 020 25466000 / 25384523

Mobile : 94220 00584

E-mail : girjawagh@gmail.com

5<sup>th</sup> February 2010

To,  
All the members of  
FOGSI.

**Re: FOGSI –Family Mediclaim Policy**

FOGSI has negotiated with United India Insurance Co. Ltd a mediclaim policy for the members and their families which is very attractive and reasonable.

The features and the form of the Policy are enclosed herewith. Kindly go through the same in details. If you have any query in this regards, please contact the FOGSI office or Mr. Chandrakant Narsinghpura on the following **Mobile No- 9820183898.**

With regards,

Yours sincerely,

**Dr. P. K. Shah**  
Secretary General  
FOGSI

Encl: as above



# The Federation of Obstetric & Gynaecological Societies of India

Model Residency CHS-605, Ground Floor, Bapurao Jagtap Marg, Jacob Circle, Mahalaxmi (East), Mumbai - 400 011.

Tel. : +91-22-3295 4564 / 2302 1648 / 2302 1654 / 2302 1343 • Fax : +91-22-2302 1383

E-mail : fogsibom7.vsnl.net.in / fogsibom2007@gmail.com • http:www.fogsibom.org



## FOGSI - Family Mediclaim Policy

with

## UNITED INDIA INSURANCE CO. LTD. D.O.-4

Mercantile Bank Chamber, 19, Cawasji Patel Street, Post Box No. 1304, Hutatma Chowk, Fort, Mumbai - 400 001.

### MEMBERSHIP FORM

Date \_\_\_\_\_

#### Personal Details : (in Capital letters)

Name : \_\_\_\_\_

Address : \_\_\_\_\_

Pin Code \_\_\_\_\_

Tel. No. : \_\_\_\_\_ Mobile No. : \_\_\_\_\_ E-mail : \_\_\_\_\_

Name of the Society : \_\_\_\_\_

#### Name of the Member and Dependents (1+5) (in Capital letters) :

Sr. No.	Names	Male / Female (M/F)	Date of Birth	Age	Relationship
1					
2					
3					
4					
5					
6					

\_\_\_\_\_  
Signature of Proposer

Total Amount Paid : Rs. \_\_\_\_\_

Cheque / Draft No.: \_\_\_\_\_ Date : \_\_\_\_\_ Bank : \_\_\_\_\_

#### For Office Use Only :

Verification of Membership of Constituent Society : \_\_\_\_\_

Office Superintendent

Convenor

**FOGSI –Family Mediclaim Policy**  
With  
**United India Insurance Co. Ltd. D. O. – 4**

Category	Sum Insured	Premium
A	Rs. 5,00,000/-	Rs. 9,997/- includes 10.30 % S. T.
B	Rs. 10,00,000/-	Rs. 19,726/- includes 10.30 % S. T.

**Salient Features**

1. Policy will be provided on Floater basis covering 1 + 5 members in the family. Family means Self, Spouse, 2 Dependent Children and Parents or in Laws. No siblings are to be covered.
2. Upper Age limit shall be 80 years at the inception of the Policy.
3. Sum Insured shall be Rs. 5 Lacs and Rs. 10 Lacs on Floater basis.
4. Maternity benefits shall be covered.
5. New born babies shall be covered from day one.
6. Maternity benefit shall be restricted to Rs. 50,000/- (A) & Rs. 1,00,000/- (B). Coverage shall start from day one.
7. Preexisting diseases are covered.
8. First year exclusion and 30 days waiting period as per Standard Mediclaim policy as waived off.
9. Additions and deletions under the Policy shall be charged on prorata basis.
10. Ayurvedic treatment in Government recognized hospital as an in-patient shall be covered.
11. Policy shall be subject to cancellation clause by giving 30 days notice by either parties in which case refund shall be granted on prorata basis except in cases where the claims are settled and / or intimated.
12. Policy covers emergency ambulance charges upto Rs. 1500/-.
13. Accidental dental treatment shall be covered.
14. Limit for room rent is Rs. 3500/-for Rs. 5 Lacs per day and Rs.6000/-. For Rs. 10 Lacs, per day there is no limit of room rent for ICU.
15. Co-payment claims of parental claims is waived off.
16. Cashless facilities shall be provided through Raksha TPA.

**Mode of Payment**

The payments is to be made by **Local Cheque** or **Draft** payable in Mumbai , drawn in favour of **"FOGSI-Family Mediclaim Policy"**.

**Address:**FOGSI ,Model Residency CHS.-605, Ground Floor, Bapurao Jagtap Marg, Mahalaxmi (E), Mumbai-400 011.

Tel:91-22-32954564 / 23021648 / 23021654 / 23021343 Fax-91-22-23031383

Email: [fogsi@bom7.vsnl.net.in](mailto:fogsi@bom7.vsnl.net.in) / [fogsi2007@gmail.com](mailto:fogsi2007@gmail.com) / <http://www.fogsi.org>

*If a member furnishes any wrongful information in the application form or at any time during The membership term, the Managing Committee of this scheme shall have the right to Terminate the membership of the member concerned without any benefit.*



# United India Insurance Co Ltd

Registered & Head Office: **24 , Whites Road Chennai-600014 India.**

HOSPITALISATION AND DOMICILIARY HOSPITALISATION BENEFIT POLICY

## CLAIM FORM

Issuance of this form does not amount to admission of any liability of under the policy on the part of the insurers  
Please give the following information correctly and completely to enable us process your claim promptly.

All dates to be entered as Date / Month / Year

1. Name of the Insured: **THE FEDERATION OF OBSTETRIC AND GYNAECOLOGICAL SOCIETIES OF INDIA (FOGSI)**

2. Name of the Doctor member : \_\_\_\_\_

Name of the claimant. : \_\_\_\_\_

(In respect of whom claim is made)

(a) Name & Relationship with the Insured : \_\_\_\_\_

(b) Present Completed Age : \_\_\_\_\_

(c) Occupation : \_\_\_\_\_

(d) Residential Address : \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

3. Policy Number (in Full) : **020400/48/08/41/00011925**

Policy Period : **31 MARCH 2009 TO 30 MARCH 2010**

**TPA Card No.** : \_\_\_\_\_

**E-MAIL id** : \_\_\_\_\_

4. Nature of Disease/Illness contracted or injury sustained : \_\_\_\_\_

5. Date on which injury was sustained/Disease Or illness first detected : \_\_\_\_\_

6. (a) Name and Address of the attending Medical Practitioner : \_\_\_\_\_

Pin Code \_\_\_\_\_

State/ U. Territory \_\_\_\_\_

(b) Qualification & Telephone No. : \_\_\_\_\_

(c) Registration No. : \_\_\_\_\_

d) Name & Address of the Hospital/Nursing Home / Clinic : \_\_\_\_\_

\_\_\_\_\_

- Pin Code \_\_\_\_\_  
State / U. Territory \_\_\_\_\_
- (b) Date of Admission : \_\_\_\_\_
- (c) Date of Discharge : \_\_\_\_\_
8. If the Claim is for Domiciliary Hospitalization, Please indicate : \_\_\_\_\_
- (a) Date of Commencement of treatment : \_\_\_\_\_
- (b) Date of Completion of treatment : \_\_\_\_\_
- (c) Name & Address of attending Medical Practitioner : \_\_\_\_\_  
Pin Code : \_\_\_\_\_  
State / U. Territory \_\_\_\_\_
- (d) Telephone No. : \_\_\_\_\_
- (e) Registration No. : \_\_\_\_\_
9. Are you at present covered under any other similar type of scheme like P.A. Cancer Insurance, Medclaim (Individual or Group), Health Insurance, etc. If Yes. Please give particulars of each
- (a) Is this the first year of coverage under Medclaim Policy? Yes / No.  
If no, since when have you been continuously insured under Medclaim Policy. Give details
- (b) (i) Is this the first claim under this policy ? Yes/No  
(ii) If no, please quote Previous claim number and details

In support of the above claim, I enclose the following original documents (Please indicated by )

1. Bill, Receipt and Discharge certificate / card from the Hospital.
2. Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.
3. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests.
4. Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.
5. Attending Doctor's/ Consultant's/ Specialist's / Anesthetist's bill and receipt, and certificate regarding diagnosis.
6. In case of Domiciliary Hospitalisation, receipt from a qualified nurse who attended the patient at his/her residence duly supported by a certificate from attending Medical Practitioner.
7. Certificate from attending Medical Practitioner giving reasons for allowing treatment at home.
8. Certificate from attending Medical Practitioner / Surgeon that the patient is fully cured.

Summary of expenses incurred for which original bills / receipts / cash memos are enclosed.

Total of Hospital Bill	Rs. _____
Consultant's /Surgeon's /Anesthetist's Fees	Rs. _____
Diagnostics Tests	Rs. _____
Medicines purchased from chemists	Rs. _____
Other expenses not included above	Rs. _____
Grand Total	Rs. _____

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.

I ALSO CONSENT AND AUTHORISE THE THIRD PARTY ADMINISTRATOR TO SEEK MEDICAL INFORMATION FROM ANY HOSPITAL / MEDICAL PRACTITIONER WHO HAS AT ANY TIME ATTENDED ON ME.

I authorize TPA to make payment of the claim admissible as per terms, conditions and limitations of the policy to the hospital on my behalf for full and final settlement of hospital bills.

I also authorize TPA to receive payment from insurance company as reimbursement of hospital bills incurred on my treatment

Dated at..... this..... day of.....

Signature of the Claimant (Doctor member) .....

**Kindly note address of the Raksha TPA office can be viewed at [www.rakshatpa.com](http://www.rakshatpa.com)  
Please log on our FOGSI website [www.fogsi.org](http://www.fogsi.org) (Publication folder) for detail information.**