Outdoor Medical Claim Form

Policy No : G/010/SHE/…….. Member No:……..

Name of Insured :……..
(Company Name)

Name Of the Employee :……..

Contact No :……..

Department :……..

Bill Date	Name of the Patient	Relationship to the Employee	Nature of Illness	Amount of Expenditure
			Total Amount Claimed	

We declare that the particulars given above are true and correct.

……
Signature of the Insured

……..
Authorized Person's Signature
(HR Department)

……
Date

……
Date