INSURANCE CLAIM FORM

Claim Number:	CLM-2024-001234
Date Filed:	2024-09-20
Policy Holder Name:	John Anderson
Policy Number:	POL-789456123
Type of Claim:	Medical
Date of Incident:	2024-09-15
Claimed Amount:	$12,500.00

Incident Description:

Patient experienced severe abdominal pain and was admitted for emergency surgery.

Declaration:

I hereby declare that the information provided above is true and accurate to the best of my knowledge. I authorize the insurance company to investigate this claim and contact relevant medical facilities for verification.

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Signature of Policy Holder