**MEDICLAIM INSURANCE - CLAIM FORM**

**DATE:**

**This claim form is valid only to process uploaded online claims during COVID – 19 lock down and employees have to submit required claim form along with original claim documents mandatorily.**

|  |  |
| --- | --- |
| 01. Name of the Corporate |  |
| 02. Name of the Insured person **(Employee)** |  |
| 03. Employee No. |  |
| 04. Contact No. & E-mail ID |  |
| 05. Name of the patient |  |
| 06. FHPL UHID No. of the patient |  |
| 07. Relationship with employee, Age & Sex |  |
| 08. Nature of illness |  |
| 09. Name of the Hospital where treated and Address of the Hospital |  |
| 10. Date of Admission |  |
| 11. Date of Discharge |  |
| 12. Amount Claimed in Rupees |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Sl.**  **No.** | **Bill No.** | **Date** | **Amount** | **Sl.**  **No.** | **Bill No.** | **Date** | **Amount** | **Sl.**  **No.** | **Bill No.** | **Date** | **Amount** |
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| (Please attach a separate sheet for more number of bills and receipts) **TOTAL** | | | | | | | | | | |  |

I/We hereby declare below points:

* **Above details are true to the best of my/our knowledge and belief that I/We did not suppress any information.**
* **Hard copies will be submitted post return to normalcy, as soon as asked for**
* **All claim documents (hard copies) if do not match with uploaded documents entire amount is recoverable.**
* **I have not made claim elsewhere.**

**Signature of the Employee**

**Please safeguard all the documents which are being uploaded for processing.**