# HEALTH INSURANCE CLAIM FORM

**ALL FIELDS IN THIS FORM ARE MANDATORY AND THE CLAIM WILL NOT BE PROCESSED IF ANY OF THE DETAILS MISSING**

## POLICY DETAILS

**Policy ID: QRST**

**Policy Start Date: 01/01/2019** **Policy End Date: 31/12/2019**

**Claimant ID Number: 58972-1620-1999**

**Corporate Name: BAJAJ ALLIANCE**

## PERSONAL DETAILS OF PROPOSER

**Name of the Proposer: HARLEY QUINN**

**Employee Number: 8576452611**

**Date Of Joining The Policy(DOJ): 01/01/2019**

**E-mail of the Proposer: puddin@gmail.com**

**Contact Number: 8300216987**

## CLAIMANT/PATIENT DETAILS

**Name of the Patient: THE JOKER**

**Relationship With the Claimant/Patient: SPOUSE**

**Date of Birth of The Claimant:01/10/1996** **Age: 21**

**Gender : Male**

**Residential Address : 11-Arkham Asylum,**
**Gotham City, United States**

## CLAIM DETAILS

**Sum To Be Insured : 1700000**

**Claimed amount in words : SEVENTEEN LAKHS RUPEES**

**1.Provisional Disease/Nature of Disease : MENTAL ILLNESS**

**2.Date of Admission : 09/4/2019**

**3.Date of Discharge : 21/11/2019**

## ENCLOSURE CHECK LIST

1. **Discharge Summary**
2. **All Bills and their Receipts**
3. **All Reports and Prescriptions**
4. **Certificate regarding Diagnosis**

**Signature Of Proposer**
**(**HARLEY QUINN)