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: ABCD

Policy Start Date: 01/01/2018 **Policy End Date: 31/12/2018**

Claimant ID Number: 58972-1620-1365

Corporate Name: BAJAJ ALLIANCE

PERSONAL DETAILS OF PROPOSER

Name of the Proposer: JHONSON FERNANDEZ

Employee Number: 8576456421

Date Of Joining The Policy(DOJ): 01/01/2018

E-mail of the Proposer: jhonson99@gmail.com

Contact Number: 8300216987

CLAIMANT/PATIENT DETAILS

Name of the Patient: CHRISTOPHER FERNANDEZ

Relationship With the Claimant/Patient: Parent

Date of Birth of The Claimant:01/10/1998 **Age: 19**

Gender : Male

Residential Address : 10-Galaxy Avenue,Parsons Housing Unit, Ramanathapuram,Coimbatore-641036.

CLAIM DETAILS

Sum To Be Insured : 1000000

Claimed amount in words : TEN LAKHS RUPEES

1.Provisional Disease/Nature of Disease : HEART TRANSPLANTATION

2.Date of Admission : 06/11/2018

3.Date of Discharge : 31/12/2018

ENCLOSURE CHECK LIST

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

Signature Of Proposer

(JHONSON FERNANDEZ)