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: IJKL

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

Claimant ID Number: 58972-1620-1367

Corporate Name: BAJAJ ALLIANCE

PERSONAL DETAILS OF PROPOSER

Name of the Proposer: JOHN WICK

Employee Number: 8576456467

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

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

Contact Number: 8300216609

CLAIMANT/PATIENT DETAILS

Name of the Patient: KEANU REEVES

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, Wall Street, United States.

CLAIM DETAILS

Sum To Be Insured : 1500000

Claimed amount in words : FIFTEEN LAKHS RUPEES

1.Provisional Disease/Nature of Disease : BRAIN TUMOUR

2.Date of Admission : 16/11/2019

3.Date of Discharge : 31/12/2019

ENCLOSURE CHECK LIST

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

Signature Of Proposer

(JOHN WICK)