HOSPITALIZATION CLAIM FORM

GROUP LIFE

A. DETAILS

Scheme Details

Scheme Name: _____

Employee Details

Name: _____

Identity Number: _____ Date of Birth: _____

Signature: _____ Date: _____

B. HOSPITAL DETAILS (TO BE FILLED BY THE DOCTOR)

Hospital Name: _____

Date of Incident: _____

Date of Admission: _____ Date of Discharge: _____

Name of Attending Doctor: _____

Signature: _____ Date: _____

Hospital Stamp

C. PAYMENT DETAILS (TO BE FILLED BY THE EMPLOYER)

Payee Name: _____ Bank Name: _____

Branch: _____ Account Number: _____

Company Stamp

Click to Submit

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Regulated by the Insurance Regulatory Authority