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 _____

PAYMENT DETAILS (TO BE FILLED BY THE EMPLOYER)

Payee Name: _____ Bank Name _____

Branch: _____ Account Number: _____

Company Stamp

Click to Submit

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