Claim Form - 'Hospi-Cash'

HEALTH INSURANCE

To be filled by the insured. Please fill in CAPITAL only.

Details of Insured

Employee/Customer Name : (First Name) (Last Name)

PatientCust.ID :

Patient Name :

Policy No. : Contact No.:

E-mail :

Medical Expense Details

Hospital-cash		Amount	Patient Client ID
DOA			
DOD			
Diagnosis			
Name of Hospital			

NEFT Details

I _____ in the capacity of Insured request you to transfer the payment(s) directly to my Bank account, details of which are mentioned below:

Particulars of Bank Account

Account Holder's Name :

Bank :

Account Number :

(Please mention the complete account number as appearing on the cheque book)

Type of Account : ☐ Savings Account ☐ Current Account Others (Please specify) : _____

Branch Address :

IFSC Code

(Please refer your cheque book or your bank branch for IFSC code details)

☐ I have enclosed a photocopy of the personalized cancelled cheque.

(In case the attached cheque copy does not bear the account holder's name, please provide photocopy of Bank statement or else Bank attestation is required)

I hereby declare that the particulars given above are correct and complete. If the transaction is delayed or not effected at all for reasons of incomplete or incorrect information, I would not hold Care Health Insurance Company Limited responsible. Further, Care Health Insurance Company Limited reserves the right to use any alternative payout option(s) including Cheque/Demand draft inspite of opting for NEFT option.

Date : Signature of the Applicant : _____

Notes: