Prime Insurance Company Ltd.

Unique Heights (9th Floor)

117, Kazi Nazrul Islam Avenue, Dhaka-1000

GROUP CLAIM FORM

Issuance of this form does not amount to admission of any liability of under the policy on the part of the insurers. Please give the following information correctly and completely to enable us process your claim promptly.

All dates to be entered as Date / Month / Year

Employee ID No.:

1.Name of the Insured:
(in whose name policy is issued)

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2. Details of the Insured person : ____________________
   (in respect of whom claim is made) :
   (a) Name & Relationship with the Insured : ____________________
   (b) Present Completed Age : ____________________
   (c) Occupation : ____________________
   (d) Residential Address : ____________________

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   (e) Bank Details
   (i) Account No ____________________
   (ii) Name of the Bank ____________________
   (iii) Branch ____________________

3. Policy Number (in Full) : ____________________
4. Nature of Disease/Illness contracted or injury sustained ____________________
5. Date on which injury was sustained/Disease
   Or illness first detected : ____________________
6. (a) Name and Address of the attending : ____________________
   Medical Practitioner : ____________________
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   ____
   (b) Qualification & Telephone No. : ____________________
   (c) Registration No. : ____________________
   (d) Name & Address of the Hospital/Nursing

Home / Clinic : ______________________

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(e) Date of Admission : ______________________

(f) Date of Discharge : ______________________

7. Are you at present covered under any other similar type of scheme like P.A. Cancer Insurance, Mediclaim (Individual or Group), Health Insurance, etc. If Yes. Please give particulars of each

Sr. No.	Contents	Details
	Name of Insurer Insurance Scheme Policy No. Period of cover Claim Amt. Recd./receivable	

(a) Is this the first year of coverage under health Insurance Policy? Yes / No.
If no, since when have you been continuously insured under Health Insurance Policy. Give details

Year	Insurer	Policy No.

(b) (i) Is this the first claim under this policy ? Yes/No

(ii) If no, please quote Previous claim number and details

Year	Policy No.	Insurer	Disease/Ailment/Injury details	Amount claimed and receivable or received

In support of the above claim, I enclose the following original documents (Please indicate)

1. Bill, Receipt and Discharge certificate / card from the Hospital.
2. Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.
3. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests.
4. Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.
5. Attending Doctor's/ Consultant's/ Specialist's / Anesthetist's bill and receipt, and certificate regarding diagnosis.
6. Certificate from attending Medical Practitioner / Surgeon that the patient is fully cured.

Summary of expenses incurred for which original bills / receipts / cash memos are enclosed.

Total of Hospital Bill	Tks. ____________________
Consultant's /Surgeon's /Anesthetist's Fees	Tks.. ____________________
Diagnostics Tests	Tks. ____________________
Medicines purchased from chemists	Tks. ____________________
Other expenses not included above	Tks. ____________________
Grand Total	Tks. ____________________

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.

Dated at.................................... this..................... day of........................

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Signature of the Claimant