Shanta Life Insurance PLC
Shanta Western Tower, Level-10
186 Bir Uttam Mir Shawkat Sarak
Tejgaon I/A, Dhaka-1208, Bangladesh
info@shantalife.com

Health Insurance Claim Form

Claim Type	Out Patient	In- Patient
	☐ General ☐ Optical ☐ Dental	☐ Hospitalization ☐ Accidental Medical Reimbursement ☐ Maternity

Organization's Name (If Group Insurance):

Policy Number/Member ID:

Employee's Office ID Number (If Group Insurance):

Mobile No: Email:

1. Policy Holder's/Employee's Name: _____
2. Policy Holder's/Employee's Age: _____
3. Patient's Name: _____
4. Patient's Age: _____
5. Patient's Relation with Policy Holder/Employee: ☐ Self ☐ Husband ☐ Wife ☐ Son ☐ Daughter
6. Nature of Sickness/Accident : _____
7. Total Claim Amount (As Per Submitted Documents): _____

Date of Admission: _____ Date of Discharge: _____

Name of Hospital/Clinic: _____

Area of Hospital/Clinic: _____

Policy Holder's/Employee's Bank Accounts Related Information:

1. Account Name: _____ 2. Bank Name: _____
3. Branch Name: _____ 4. Account Number: _____
5. Routing Number: _____

(Please Attach A Photocopy Of MICR Cheque Leaf)

Authorization

I hereby certify that all answers and all documents submitted with the Claim Form are complete and true. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any other company, institution or any other person who has any record or information about me and/or any of my family members to provide Shanta Life Insurance PLC with the complete information, including copies of their records with reference to any sickness or accident, any treatment,examination advice or hospitalization. Any photocopy of this authorization shall be taken as the original copy.

_____ _____

Signature of the Policy Holder/Employee with date

Signature of the Authorized Person with Date & Seal

(Applicable only for Group Customers)

Please attach following documents with this Claim Form

Out-Patient Treatment

- Original money receipt showing the attending physician's detailed charges along with his/her Seal signature & date with photocopy of physician's prescription.
- Original itemized pharmacy bill showing the date of purchase, name of patient, quantify and name of drugs along with photocopy of physician's prescription.
- Original receipt showing charges for each of the Laboratory tests and other examinations done, supported by the respective physician's request to undergo examinations and photocopies of the results of examinations undertaken.

In-Patient Treatment

- Copy of Prescriptions of respective physician containing Hospitalization advice
- Itemized original hospital bill supported by the official receipt for the total amount paid.
- Original receipt showing attending Physician's/Surgeon's charges along with his stamp and signature.
- Photocopy of detailed hospital discharge Certificate and others treatment documents.

N.B. Company may ask for additional information and documents, if deemed necessary.