Health Insurance Loss Claim Form

1. Policy Holder Details

Policy Number

Policy Holder's Name

Date of Birth

Contact Number

Address

2. Patient Details

Patient Name

Relationship to Policy Holder

Hospital Name

Date of Admission

Date of Discharge

3. Claim Details

Claim Amount (in words)

Claim Amount (in figures)

Reason for Claim

4. Bank Details (for Claim Payment)

Bank Name

Branch

Account Number

IFSC Code

Account Holder Name

5. Declaration

I hereby declare that the details provided above are true and correct to the best of my knowledge and belief. I agree to provide any further information or documentation, if required by the insurance company.

Signature of Policy Holder

Date

Important Notes

- Complete the form accurately to avoid delays in claim processing.
- Attach all required hospital bills, discharge summary, and prescription copies.
- Incorrect or incomplete details may lead to claim rejection.
- Keep copies of all documents submitted for your records.
- Contact your insurer for clarification on any section of the form.