An ISO 9002
Certified Company

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Karachi Lahore Islamabad Faisalabad Multan Sialkot Gujranwala Peshawar

IGI INSURANCE LIMITED

MEDICAL INSURANCE CLAIM FORM

Claim No. _____

1. Name of Insured _____
2. Name of Employee _____
3. Name of Patient _____ Age _____
4. Date of Illness/Accident / Hospitalization _____
5. State where and when a medical or other officer of the company can visit the patient, if necessary _____

   _____
6. state the period during which thepatient has been totally disabled from attending to his / her business as a sole and direct result of the illness/accident _____
7. Is the patient still totally disabled? If not from what date is he/she likely to attend to some part of his/her business

   _____
8. Has the patient previously claimed or recieved compensation under an accident & / or sickness policy? If so please give details _____
9. a) Is the patient insured elsewhere? _____

   b) If so, give the name of each company of insurer, and amount you are Entitled to claim _____

   _____

We the undersigned, do hereby declare that, to the best of our knowledge and belief, the foregoing particulars are true and correct.

Employee's Signature _____ ***Insured's Signature & Stamp*** _____

Date _____