



Allied Insurance Company

of the Maldives Pvt Ltd

PHONE : 324612, FAX: 325035 / EMAIL: info@alliedmaldives.com

HEALTH INSURANCE CLAIM FORM

DETAILS OF INSURED

Company Name:

Company Address:

Policy Number:

DETAILS OF CLAIMANT

Name of Staff: Phone No:

ID card No: Health Card No:

(Fill only if Claimant is Dependent)

Name of Dependent: Phone No:

ID card No: Health Card No:

DETAILS OF TREATMENT

Name of Authorized Medical centre:

Name of Doctor: Date of Consultation:

Details of Illness/Diagnosis:

If you would like an Account Transfer please tick in the box

* Bank Charge has to be borne by the account holder

Please provide all the paid Memos, Prescription and bills along with this claim form **within 60 days** of treatment received. All the details mentioned above must be filled when submitting the form.

I/WE DECLARE the forgoing particulars to be true and correct and undertake to render every assistance in my/our power in dealing the matter.

Total Amount Claimed:

Signature:

Date: