



Allied Insurance Company of the Maldives Pvt. Ltd

04-06 S.T.O Trade Centre, Orchid Magu, Male', Maldives
Phone: (960) 332 4612, Fax (960) 332 5035

Web site: www.alliedmaldives.com, Email: info@alliedmaldives.com

Health Insurance Claim Form

Claim No: _____

Details of the Insured

Name of Insured: _____

Address: _____

Occupation: _____

Policy No: _____

Details of the Employee/Claimant

Name of the employee/patient: _____

I.D Card No: _____

Employee card No: _____

Address: _____ Contact No: _____

Date of consultation: _____

Name of the Authorized Medical Centre: _____

Name of the attending doctor: _____

Details of the illness / injury: _____

Have you ever claim under this policy?

If so claim no: _____

Please provide all the paid prescription and bills along with this claim form.

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

Signature: _____

Date: _____

Amount of claim _____

Reimbursed amount _____

In Reimbursement please credit my account no. _____