Surgical Expense Claim Form

1. Policyholder Information

Full Name

Policy Number

Date of Birth

Contact Number

Address

2. Patient Information

Patient Name

Relationship to Policyholder

Patient Date of Birth

3. Surgery Information

Date of Surgery

Hospital Name

Surgeon's Name

Description of Surgery

4. Expense Details

Total Surgical Expense (â‚¹/USD)

Date of Bill

Bill Details / Reference No.

5. Bank Details

Bank Name

Account Holder's Name

Account Number

IFSC/SWIFT Code

Branch

6. Declaration

I declare that the information provided above is true and correct to the best of my knowledge. All relevant bills and documents are attached.

Signature of Policyholder

Date