CLAIM INTIMATION FORM

GROUP LIFE & HEALTH INSURANCE DEPARTMENT
Protective Islami Life Insurance Ltd.
Tel: 88-02-9840616-7, Fax: 88-02-9840618

FROM :.....

SUBJECT **HOSPITALIZATION CLAIM INFORMATION, CONTRACT NO. .....**

(To be completed by employee)
Please use block letters all through

1. Name of Employee:	
2. Employee ID:	
3. Designation:	4. Branch/Div./Dept:
5. Name of Patient:	
6. Relationship of Employee (if the patient is a spouse/dependent):	
8. Date of Admission:	7. Membership No:
9. Name of Hospital:	
Address:	
Telephone No.	
10. Name of Doctor:	
11. Nature of Illness:	
12. Treatment Advised:	
13. Expected Date of Discharge:	

_____ _____

Signature of Employee with date: **Signature of Plan Secretary with Seal**

Copy to:

N.B.: *Please send this information directly to Protective Islami Life Insurance Ltd. by FAX before or at the time of admission to a hospital/clinic and mail original copy to Head Office-HRD- ..... for necessary action.*