



প্রোটেক্টিভ ইসলামী লাইফ ইনস্যুরেন্স লিমিটেড
Protective Islami Life Insurance Limited
Protect Your Future

Claim Form (In-Patient)

(Please use BLOCK letters all through)

Name of the Organization:

Contract No:

Employee Name:	
Employee ID No.:	
Patient Name:	
Relationship of Employee (if the patient is a dependent):	
Date of Prior Intimation: (DD/MM/YYYY)	Membership No:
Name & Address of Hospital:	
Date of Admission: (DD/MM/YYYY)	Date of Discharge: (DD/MM/YYYY)
Bank/bKash Account Name:	
Bank/bKash Account No.:	
Bank Name:	
Bank Branch:	Routing No.:
Breakup of Hospitalization Expenses	
Cost, Charge & Fees in respect of	Amount (Taka)
Hospital Accommodation	
Consultation Fee	
Routine Investigations	
Medical & Drugs	
Surgical Charges	
Ancillary Services	
Others	
Total	
_____ Signature of Employee Date:	_____ Signature of the Div./Dept. Head Date:
To be filled in by Head Office – HRD,)	
Forwarded for necessary action to	
_____ Signature of Plan Secretary with Seal	 GROUP LIFE & HEALTH INSURNACE DEPT. Protective Islami Life Insurance Ltd. H/O: H.R Complex (5 th Floor), 100, Bir Uttam A.K Khandakar Road, Mohakhali C/A, Dhaka-1212

N.B: Please note that reimbursement of the claim can only be made when all original documents and bills are submitted together with this form as mentioned on leaf. **ALL CLAIMS SHOULD BE SUBMITTED THROUGH THIS FORM.**

Required during submission of claim for reimbursement:-

1. Copy of **Claim Intimation Record**
2. Consultant/Attending **Physician's recommendation for hospitalization**
3. **Claim Form** duly filled in by the employee
4. Copy of **Discharge Certificate** from the hospital/clinic
5. Photocopy of patient's **Treatment Records** while confined in hospital/clinic
6. Photocopy of patient's **Investigation Report** while confined in hospital/clinic
7. Original **Bills** specifying:-
 - a. **Accommodation Charges** (mentioning daily charge with number of days in hospital)
 - b. **Consultant's Fee** (receipts with date)
 - c. **Routine Investigation** (mention charge for each investigation separately)
 - d. **Medicine & Drugs** (original bills mentioning name, quantity & price of each)
 - e. **Surgical Charges** (mention fees for surgeon, O.T., Anesthetist, Assistant etc)
 - f. Charges for **Ancillary Services** (Labor Room Service, Post Operative Care Facilities, Oxygen Therapy, Intensive Care Facility, Blood Transfusion, Ambulance Service, Dressing, Tests Other Than Routine Investigation, Ambulance Services etc.)
 - g. Service charge, telephone, food & beverage
 - h. VAT etc.

For Official Use of Protective Islami Life Insurance Ltd

Date of Receipt:

Prior Intimation Date:

Signature of Recipient:

Head of Group L&H

Date of Receipt of Complete Papers:

Reimbursed Amount: TK

Date of Reimbursement:

Authorized Signature

Date: