Benign Brain Tumor Claim Form

Policy Holder Details

Full Name

Date of Birth

Policy Number

Contact Number

Address

Patient Details

Patient Name

Relationship to Policy Holder

Date of Birth

Gender

Medical Information

Date of Diagnosis

Name of Treating Doctor

Hospital/Clinic Name

Description of Condition

Claim Details

Claim Amount

Other Health Insurance Coverage

Supporting Documents

Diagnosis Report

Choose File No file selected

Medical Bills

Choose File No file selected

Other Documents

Choose File No file selected

Declaration

I hereby declare that the information provided is true and correct to the best of my knowledge.

Signature

Date