Cancer Insurance Claim Form

Policyholder Information

Full Name

Policy Number

Date of Birth

Contact Number

Email Address

Address

Patient Details

Is the patient the policyholder?

Relationship to Policyholder

Patient Full Name

Date of Birth

Gender

Cancer Diagnosis Information

Date of Diagnosis

Type of Cancer

Stage / Grade (if known)

Hospital / Clinic Name

Attending Physician

Treatment Details

Treatment Type

Treatment Start Date

Treatment End Date

Details of Treatment Received

Claim Details

Amount Claimed

Bank Account Name

Bank Account Number

IFSC / SWIFT Code

Declaration & Signature

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

Date