Kidney Failure Insurance Claim Form

Policyholder Name

Policy Number

Date of Birth

Contact Number

Email Address

Patient Name

Relationship to Policyholder

Patient Date of Birth

Date of Diagnosis

Treating Hospital/Clinic

Consulting Doctor's Name

Details of Kidney Failure Diagnosis

Treatment Received (Dialysis, Transplant, etc.)

Claim Amount

Bank Account Details for Payout

Additional Comments

Date

Signature