Severe Burns Insurance Claim Form

Personal Details

Full Name

Policy Number

Date of Birth

Address

Phone Number

Email Address

Incident Details

Date of Incident

Location of Incident

Description of Incident

Degree of Burns

Area of Body Affected

Were you hospitalized?

Details of Treatment Received

Medical Information

Name of Hospital / Clinic

Attending Physician

Physician Contact Information

Date of Admission

Date of Discharge

Additional Information

Other Insurance Coverage

Additional Comments

Declaration

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

Signature

Date