

Ship Crew Medical Insurance Claim Form

1. Crew Member Details

Full Name

Date of Birth

Gender

Nationality

Passport / Seaman's Book No.

Rank/Position

Contact Number

Email

2. Vessel & Employer Details

Vessel Name

IMO Number

Flag

Ship Owner / Employer Name

Employer Contact Details

3. Medical Details

Date of Illness / Injury

Place of Incident

Type of Illness/Injury

Description of Illness / Injury

Date First Consulted Doctor

Hospital/Clinic Name

Doctor's Name

Treatment Given

4. Claim Details

Amount Claimed

Details of Expenses (Medical, Hospital, Others)

Bank Details for Reimbursement (Account Name, Bank, IBAN/SWIFT, etc.)

5. Declaration

I declare that the above information is true and complete to the best of my knowledge.

Name of Claimant

Signature

Date