Child Health Insurance Claim Form

Policyholder Information
Full Name

Policy Number

Date of Birth

Contact Number

Address

Child Information
Child's Full Name

Date of Birth

Gender

Relationship to Policyholder

Treatment Details
Date of Admission

Date of Discharge

Name of Hospital/Clinic

Reason for Hospitalization

Doctor's Name

Claimed Expenses
Total Amount Claimed

Details of Expenses

Bank Details (for claim amount transfer)
Bank Name

Account Number

IFSC Code

Account Holder Name

Declaration

I hereby declare that the details provided are true & correct to the best of my knowledge.

Date

Signature