COVID-19 Health Insurance Claim Form

Personal Information Full Name					
Date of Birth					
Policy Number					
Contact Number					
Address					
Hospitalization Details					
Hospital Name					
Date of Admission					
Date of Discharge					
Diagnosis (COVID-19 confirmation)					
Claim Details Claim Amount					
Claim Amount					
Bank Name					
Account Number					
IFSC Code					
Declaration					
I hereby declare that the information provided is true and correct to the best of my knowledge.					