Your Trusted Risk Manager

সেনা কল্যাণ ইন্স্যুরেন্স কোম্পানী লিঃ

**Sena Kalyan Insurance Company Ltd.**

(A Concern of Sena Kalyan Sangstha)

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# OVERSEAS MEDICLAIM CLAIM FORM

(To be submitted at the time of making a claim-please use block letters)

1. Name o Employer
2. Contact Number
3. Name of Patient
4. Name of Employee's
   (In case of dependant)
5. Membership Number — 6.Plan Type
7. Name of Hospital/Clinic
8. Name of Consultant
9. Date of Admission — 10.Date of Discharge
11. Diagnosis
12. Treatment
13. Has the patient been discharged by the consultant — Yes ☐ No ☐
14. Total amount of Charges — Tk.

Signature of Employee

Signature of Plan Coordinator
Or Hospital Representative

Date

Date

Reimbursement of claims can only be made when all the original documents and bills are submitted together with this form. See overleaf

Note: Please enclose the Doctor's Advice Note for hospitalization

1. Name o Employer
2. Contact Number
3. Name of Patient
4. Name of Employee's
   (In case of dependant)
5. Membership Number | 6.Plan Type
7. Name of Hospital/Clinic
8. Name of doctor
9. Nature of Illness

10. Treatment Advised

Signature of Primary Member
(Signature of Employee)

Signature of Primary Member
(For Corporate Clients Only)

Date

Date