THE ORIENTAL INSURANCE CO. LTD

Divisional Office 3
K F C Building # 48, Church Street, Bangalore -560 001

Phone: 25588381/25588260 Telefax: 25595964 E-mail: oic_do3@dataone.in

MEDICLAIM INSURANCE CLAIM FORM

1. Name of the Employer :
2. a) Name of the Employee :
   b) Employee Number :
   c) Employee E-mail Id :

3. Details of Insured Person (In respect of whom claim is made)
   - Name :
   - Completed Age :
   - Occupation :
   - Address :

4. Nature of illness/Disease :

5. Date of Injury sustained or disease/
   Illness first detected :

6. Name and & Address of attending Medical Practitioner
   - Qualification :
   - Registration No :

7. Name & Address of the Hospital/:
   Nursing Home/Clinic

8. Date of Admission :

9. Date of Discharge :

10. Amount Claimed :

11. Previous Claim Particulars &
    Amount Claimed if any :

Date:

Signature of the Claimant