UNITED INSURANCE COMPANY LIMITED

Head Office : Camellia House, 22, Kazi Nazrul Islam Avenue, Dhaka-1000, Bangladesh
G.P.O Box No. 3569, Tel : 9664348, 8631447, 9677706, 9667999, PABX : 8619336-8
Fax : 880-2-8622330 / 8631447, E-mail : info@unitedinsurance.com.bd
Website : www.unitedinsurance.com.bd

HEALTH PLAN - CLAIM FORM

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

1. Name of Employer
2. Contract 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 tbe 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

IMPORTANT

The following documents should be submitted along with this Form at the time of making a claim

1. Copy of the Consultant's recommendation for hospitalization
2. Copy of the Discharge Certificate
3. Copy of the patient's file while hospitalized (if possible)
4. Original bill of the Consultant (physician/surgeon)
5. Original bill relating to room charges, investigation and other services where applicable
6. Original bill of medicines/drugs
7. Original bill relating to surgical operation charges (operation theatre, surgical team, anaesthesia & other charges)
8. Original bill relating to ancillary services e. g. ambulance service, oxygen therapy, blood transfusion, etc.

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HEALTH PLAN-CLAIM NOTIFICATION FORM

(To be submitted before hospitalization Please use block letters)

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

1. **Contract Number**
2. **Membership Number** **3. Plan Type**
4. **Name of Patient**
5. **Name of Primary Member**
   (Employee's Name)
6. **Name of Employer**
7. **Name of Hospital/Clinic**
8. **Name of Doctor**
9. **Nature of Illness**
10. **Treatment Advised**

Signature of primary Member
(Signature of Employee)

Date

Signature of primary Member
(For Corporate Clients Only)

Date