IGI Life Insurance Limited
Formerly 'American Life Insurance Company (Pakistan) Limited'

MEDICAL CLAIM FORM

(A) CLAIMS SUBMISSION PROCEDURE

To avoid any delays in processing of your claim, please ensure that:

1. **All questions on the form are to be answered. Do not leave any blank spaces. Use block letters.**
2. Claim is to be submitted through your employer.
3. All original claims documents are to be attached.
4. **COMPLETE THE CHECK LIST.**

(B) EMPLOYEE'S SECTION

1. Employee's Name & Date of Birth : _____
   (As shown on Enrollment Card Policy Listing)
2. Patient's Name & date of Birth: _____
   (As shown on Enrollment Card Policy Listing)
3. Group Policy No: _____Employee Cert No. _____Class_____
4. Email ID: _____Contact No. _____
5. Patient's Effective Date of Coverage : _____
6. Bank Name : _____Account No. _____

I hereby certify that all answers and all documents submitted with the Claim Form are complete and true. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any other company institution or any other person who has any record or information about me and / or any of my family members to provide **IGI Life Insurance Limited** *Formerly 'American Life Insurance Company (Pakistan) Limited'* with the complete information, including copies of their records with reference to any sickness or accident, any treatment, examination, advice or hospitalization. Any photocopy of this authorization shall be taken as the original copy. I also authorize **IGI Life Insurance Limited** *Formerly 'American Life Insurance Company (Pakistan) Limited'* to share my or my family's information with third parties if needed for processing of this claim.

Employee's Signature: _____ Date: _____

(C) EMPLOYER'S SECTION

1. Is this claim arising out of the patient's occupation? Yes ☐ No ☐
2. Cheque payment made in the name of
   - ☐ Employee
   - ☐ Employer
   - ☐ Assigned Provider
3. Total Amount Claimed: _____
4. Employer's Representative Signature: _____
5. Employer's Stamp: _____ Date: _____

(D) FOR FFICIAL USE ONLY

DOS 1	DOS 2	PC	DEP	CRVS	PROV	PAYEE	PRD	AC CD

BEN. CD	CLAIMED EXP.	APPROVED EXP.	

(E) ATTENDING PHYSICIAN'S SECTION

1. Patient's Name & Date of Birth : _____
2. Presenting Complaints: _____
3. Duration of Complaints : _____
4. Diagnosis (Block Letters): _____
5. Date symptoms first appeared: _____
6. If the claim is resulting from pregnancy/ children, please provide date of (LMP or E.D.D): _____
7. Details of Treatment (other than prescription):_____
8. Dates of any previous treatment ingrowth name of treating physician: _____
9. If further treatment or operative procedure anticipated? Yes ☐ No ☐
   If "yes" Please provide full details & expected dates.
   _____
   _____
10. Name of Operation: _____
11. Date performed: _____

Physician's/ Surgeon's Signature & Stamp: _____

Date: _____

CLAIMS CHECK LIST

KINDLY ATTACH THE FOLLOWING WITH YOUR CLAIM.
(NOTE: ORIGINAL DOCUMENTS REQUIRED)

	PLEASE TICK	
	YES	**NO (REASON)**
1. Itemized Hospital Bill & Receipts.		
2. Detailed Hospital Discharge Report.		
3. Itemized Laboratory & Radiology Bills.		
4. All Laboratory & Radiology Reports.		
5. Itemized Pharmacy Bills Along with Prescriptions		
6. Ultrasound, C.T. Scan, MRI Reports, etc.		
7. Others (If Any).		