IGI Life

PACKAGES LIMITED

Outpatient Medical Reimbursement Claim Form

Employee Name: _____ Patient's Name: _____

Group No.: _____ Cert. No.: _____ Class No. _____

Contact No.: _____ Email Add: _____

Bank Name: **NIB** _____ Bank Account No.: _____

S.No	Expense Description	Employee	Spouse	Children
1	**Consultation Fee**			
2	**Medicines**			
3	**Diagnostic Tests**			
4	**Preventive Vaccination**			
5	**Others**			
	Total			

AUTHORIZATION

I, the above claimant, hereby authorize any doctor, hospital or any other person who has any record or information about me and / or any of my family members to provide IGI Life with the complete information, including copies of their records with reference to any sickness or accident or any treatment.

Employee's Signature: _____ Date: _____

Note: Attach all original bills with doctor's prescription & referrals.

IGI Life Insurance Limited
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