



Your Trusted Risk Manager

সেনা ইন্স্যুরেন্স পিএলসি

Sena Insurance PLC

(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 Insured

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

Date

Signature of Plan Coordinator
Or Hospital Representative

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

<input type="text"/>	6. Plan Type	<input type="text"/>
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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

CLAIMANT DETAILS:

Insured Name: Title:
(Mr/Mrs/Ms/Miss/Other)

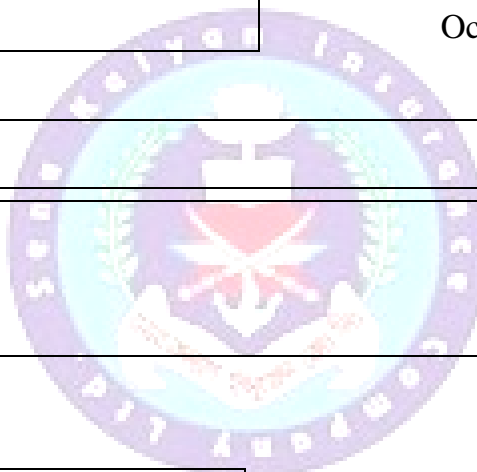
First Name: Date of Birth:

Home Address:

Home Telephone No: Work Telephone No:

Mobile Telephone No: Occupation:

Email Address:



POLICY DETAILS:

Policy Number: Date of Purchase/Issued: / /

Purchased/Issued Through:

Lead Name on Policy: (If different from claimant) Relationship to Claimant:

TRAVEL DETAILS:

Country of Destination: (If cruise, which sea?)

Date Trip Booked:

Departure Date:

Return Date:

Type of Booking:

Leisure Trip

Business Trip

Reason for trip if it is not linked with a Leisure or Business trip?

Have you made any other claims for this incident with any other Insurer?

If yes, please provide details:

