CLAIM INTIMATION

(To be filled and submitted to Grand Healthcare on admission of the patient in the Hospital)

Date: ___________

Name of Policyholder:____

Name of Patient: ____Age: _______ yrs Sex: M / F

Address for communication :____

City:___________________ State: ________________ Pin:____________ Contact No.:___________________

Grand ID number: ___________________________ Policy No.______________________________________

Name of the Insurance Company: ____

Name of Hospital:____

Address: ____ City: ________________State: _________

Diagnosis: ____Date of Admission: ____ / ____ / ____

Name of Treating Doctor: ______________________________Approximate Expenses: Rs.______________

Any other Relevant Information:____

Signature / Thumb Impression of Policyholder / Nominee

Name: ____Contact No: ________________

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