Trust us for Life

প্রগতি লাইফ
ইন্স্যুরেন্স
লিমিটেড

Pragati Life Insurance Limited

Head Office : Pragati Insurance Bhaban, (Level-3-6 & 9), 20-21, Kawran Bazar Dhaka-1215.
PABX: 8189184-8, Fax : 880-2-9124024 E-mail : health@pragatilife.com

HEALTH INSURANCE DEPARTMENT

CLAIM FORM

(Please Use block letter all through)

1. Name of Organization :	Employee ID :
2. Name of Employee :	Cell No :
3. Name of Patient:	Claim Ref. No. :
4. Relation with Employee ◯ Father ◯ Mother ◯ Husband ◯ Wife ◯ Son ◯ Daughter	
5. Date of Prior Intimation:	6. Membership No. :
7. Name of Hospital /Clinic	
8. Date of Admission :	9. Date of Discharge :
10. Breakup of Hospitalizations Treatment Expenses:-	
Cost, Charges and Fees in respect of	**Amounts (Taka)**
Hospital Accommodation	
Consultant's Fee	
Routine Investigation	
Medicines/Drugs	
Surgical Charges	
Ancillary Services	
Others	
Total	

Signature of the Employee/Claiment
Date:

Signature of the Div/Dept Head
Date :

(To be filled in by the Plan Secretary of the Organization)

Ref No. *Date:*

Forwarded to Pragati Life with the neccessary supporting documents marked over leaf for processing of the claim as per Contract.

Signature of Plan Secretary with Seal

N.B. Please note that reimbursement of claim can only be made when all original documents and bills are submitted together with this form as mentioned over-leaf. ALL CLAIMS SHOULD BE SUBMITTED THROUGH THIS FORM.