IGI Life Insurance 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.: ______________________ Class: ______________
4. Individual Certificate No.: ______________________
5. Patient's Effective Date of Coverage: ______________________

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 OFFICIAL 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/ childbirth, please provide date of (LMP or E.D.D): ______________________________

7. Details of Treatment (other than prescription): ______________________________

8. Dates of any previous treatment given with name of treating physician: ______________________________

9. If further treatment or operative procedure anticipated? Yes ☐ No ☐
If "yes", please provide full details and expected dates.

____

____

10. Name of Operation: ______________________________

1. 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 alongwith prescriptions.		
6. Ultrasound, C.T. Scan. MRI reports, etc.		
7 Others (if any).		

Complaints in Respect of Insurance Policy

If you have any complaint or grievance against the Insurance Company, Broker, Agent, Surveyor or Bank Representative in respect of your insurance policy, you may file your complaint with the following offices:

1. **Federal Insurance Ombudsman**
   2nd Floor, Pakistan Red Crescent Society, Annexe Building, Plot # 197/5, Dr. Daud Pota Road, Karachi.
   Tel: (021) 99207761-62 Website: www.fio.gov.pk

2. **Official Coordinator, Small Disputes Resolution Committee – Islamabad**
   The Management Executive, Insurance Division, 3rd Floor, NIC Building, 63 Jinnah Avenue,
   Blue Area, Islamabad.
   Tel: (051) 9207091 to 94 - Ext: 439 E-mail: complaints@secp.gov.pk

3. **Official Coordinator, Small Disputes Resolution Committee – Karachi**
   The Deputy Director, Specialized Companies Division, 5th Floor, State Life Building No. 2, Wallace Road,
   Off I.I. Chundrigar Road, Karachi.
   Tel: (021) 32414204 E-mail: complaints@secp.gov.pk

4. **Official Coordinator, Small Disputes Resolution Committee – Lahore**
   The Deputy Registrar of Companies, Company Registration Office, 3rd & 4th Floor, Associate House,
   7 - Egerton Road, Lahore
   Tel: (042) 99204962 to 66 - Ext: 28 E-mail: complaints@secp.gov.pk

بیمہ پالیسی کے متعلق شکایات

اگر آپ کو اپنی بیمہ پالیسی کے متعلق انشورنس کمپنی، بروکر، ایجنٹ، سرویئر یا بینک نمائندے کے خلاف کوئی شکایت ہو تو درج ذیل دفاتر میں رابطہ کر سکتے ہیں:۔

وفاقی انشورنس محتسب،
سیکنڈ فلور، پاکستان ریڈ کریسنٹ سوسائٹی، انیکسی بلڈنگ،
پلاٹ نمبر 197/5، ڈاکٹر داؤد پوتا روڈ، کراچی
فون: 021-99207761-62
www.fio.gov.pk

دفتری رابطہ کار (اسلام آباد)
اسمال ڈسپیوٹس ریزولوشن کمیٹی
سیکورٹیز اینڈ ایکسچینج کمیشن آف پاکستان
تھرڈ فلور، این آئی سی ایل بلڈنگ، اسلام آباد
فون: 051-9207091-4، ایکسٹینشن 439
ای میل: complaints@secp.gov.pk

دفتری رابطہ کار (لاہور)
اسمال ڈسپیوٹس ریزولوشن کمیٹی
سیکورٹیز اینڈ ایکسچینج کمیشن آف پاکستان
ایسوسی ایٹ ہاؤس، 3rd فلور، 07، ایجرٹن روڈ، لاہور۔
فون: 042-99204962-66 (Ext 28)
ای میل: complaints@secp.gov.pk

دفتری رابطہ کار (کراچی)
اسمال ڈسپیوٹس ریزولوشن کمیٹی
سیکورٹیز اینڈ ایکسچینج کمیشن آف پاکستان
5th فلور، اسٹیٹ لائف بلڈنگ 02، والاس روڈ،
آف آئی آئی چندریگر روڈ، کراچی۔
فون: 021-32414204
ای میل: complaints@secp.gov.pk