



PROTECTIVE ISLAMI LIFE INSURANCE LIMITED
GROUP LIFE & HEALTH INSURANCE DEPARTMENT

Protective Islami Life Insurance Ltd.

Tel: 88-02-984616-7, Fax-88-02-9840618

OUT PATIENT CLAIM FORM

Please use block letters all through

Name of the Organization:

Contract No.

1.Name of Employee:	
2.Name of Patient:	
3.Relationship of Employee (if the patient is a spouse/dependent):	
4.Date of prior Intimation:	5.Membership No:
6.Date of Visit:	7.Nature of Illness:
8. Breakup of Expenses:-	
Cost, Charge and Fees in respect of	Amount (Taka)
• Consultant's Fee	
• Routine Investigations:	
• Medical & Drugs:	
Total	
Signature of Employee with Date:	
Signature of the Div./Dept. Head Date:	
(To be filled in by Head Office-HRD)	
Forwarded for necessary action to	
GROUP LIFE & HEALTH INSURANCE DEPARTMENT Protective Islami Life Insurance Ltd. Head Office: H.R Complex (5 th Floor), 100, Bir Uttam A.K Khandaker Road Mohakhali C/A, Dhaka-1212	
Signature of Plan Secretary with Seal	

N.B.: Please note that reimbursement of claim can only be made when all required documents and original bills are submitted together with this form as mentioned over leaf.

Required during submission of claim for reimbursement:-

1. Copy of Claim Form.
2. Claim Form duly filled in by the employee
3. Photocopy of Prescription
4. Photocopy of patient`s Investigation Report.
5. Original Bills specifying:-
 - a. Consultant`s Fee.
 - b. Investigation Charge.
 - c. Medicine & Drugs (original bills mentioning name, quantity & price of each)



For Official Use of Protective Islami Life Insurance Ltd.

Date of Receipt:

Prior Intimation Date:

Signature of Recipient:

Head of Group L&H

Date of Receipt of Complete Papers:

Reimbursed Amount: TK

Date of Reimbursement:

Authorized Signature

Date: