Clankit
Health & Wealth, We Manage Both

Claim Intimation Form

Insured Information

Name of Insurance Company			
Policy Number			
Policy Start Date		Policy end date	
Name of Policy Holder			
Phone		Mobile Number	

Hospitalization Information

Name of Patient			
AITL Card			
Age of Patient		Sex	Male / Female
Diagnosis			
Date & Time of Admission		Admission for number days	
Conservative / Operation			
Name of Hospital			
Address of Hospital			
City		State	
Contact No. of Hospital		Mobile Number	
Contact No. of Treating Doctor		Mobile Number	
Estimated Expenses			
Hospital Networking/ Non-Networking	Insured / Patient / Relative / Agent		
Registered with local Authorities (If not networking)			
Intimation Submitted by			

I hereby authorize AITL/ Insurance Company to obtain my medical record / information from Hospital / Nursing Home /Treating Medical professionals / family physician / Diagnostic centers /Medical shops necessary to process the claim.

Signature / Thumb Impression of Patient / Relative/
Policy Holder

Name

Date