



IMA KERALA HEALTH SCHEME

Claim form

Claim No:

(For office use only)

(See instructions before filling)

1. Name of claimant:	Age:	Sex:
2. Scheme Enrolment No:	Date of joining scheme:	Renewal date:
3. Address - Permanent:	For communication	
4. Phone: (R:)	(O:)	Mob:
5. Details of previous claims - if any (in the current year)		
Date:	Amount claimed:	Amount received
6. Details of present claim:		
Date of Admission:	Discharge:	No. of days in hospital:
7. Diagnosis	:	
8. Details of hospital(s) treated:		
Name of Hospital:	Address:	Phone:
9. Name(s) of Doctor(s) treated:		
10. Amount of claim (Total)	:	
(a) Room rent	:	
(b) Food	:	
(c) Travel	:	
(d) Special charges (if any)	:	
11. Details of documents submitted	:	
(Originals mandatory)		

12. Whether you request to get original documents returned :Yes / No.

13 Bank name, Branch Name, IFSC Code. Account no(To receive payment)

14. Status of IMA membership: *Life member / Annual member: Renewed/Not renewed*

Affidavit:

I,do hereby declare that the details submitted above is true and correct to best of my knowledge and are bonafide record of the charges incurred during the treatment.

Date:

Signature:

Place:

Name:

For office use

Status of scheme membership : *Valid / Not renewed*

Date of enrolment :

Last renewed on:

Membership Year :

Next renewal :

Claims during present membership year :

1.	
2.	
3.	
4.	
5.	
Total	

Balance amount in present membership year : Rs.

Status of IMA membership (After HQ verification):

Total Amount Claimed			Remarks
Deductions			
Calculation:			
Upper limit of the claim			
Payment allotted:			

Signature of Scheme Secretary