



**Industrial Research & Consultancy Centre
Office of the Dean R & D**

Claim Form for Reimbursement of Premium of Mediclaim Policy

1. Name of the Employee :- _____

2. Employee Code :- _____ 3. Designation : _____

4. Department :- _____ 5. Date of Joining : _____

6. Tenure of Appointment :- From / / to / /

7. Details of Policy

a. Name of Company :- _____

b. Date of Issue :- ___/___/_____ (Attach Xerox copy of policy and premium receipt)

Sr. No.	Name of Person Insured	Relation	Age	Serial No. of policy	Sum Assured	Validity period (from and to)	Amt of Premium
01		Self					
02		Spouse					
03							
04							
Total Amount of Premium paid							

Declaration :-

- I hereby declare that the information given in this application is true to the best of my knowledge and that the person for whom policy taken is/are wholly dependant upon me. Also I have not made such claim from any other sources.
- Any other remark :- _____

Date :- / /2006

Signature of Applicant

(For Office Use only)

Certified that the information given above is found correct as per our records. The claim is as per rules and is supported by necessary documents. Recommended for reimbursement.

Dy. Registrar (R & D)

Dean (R & D)

A claim of Rs. /- (Rupees) only) as sanctioned by
Dean (R & D) is reimbursed vide bill No. Dtd. / / 2006