AYADY TAKAFUL
ALLIED ISLAMIC WINDOW

Expatriate Health Insurance
Claim Form

DETAILS OF EMPLOYER

Name of Employer		Phone No.	
Policy Number			

DETAILS OF INSURED

Name of Insured	
Passport No.	

DETAILS OF TREATMENT

Name of Authorised Medical Center	
Period of Consultation	
Details of Illness/Diagnosis	

PLEASE CHECK WHETHER YOUR CLAIM FORM IS COMPLETE AND THE FOLLOWING DOCUMENTS ARE INCLUDED

☐	Doctors Prescription/Medical Reports	☐	Original Bills
☐	Discharge Summary (Only Inpatient)	☐	Original Memo

Claims need to be submitted within 60 Days. Failure to do so will result in Claim Rejection

I/WE DECLARE the forgoing particulars to be true and correct and undertake to render every assistance in my/our power in dealing with the matter. I have completely filled the claim form and enclosed all the necessary documents. I acknowledge that failure to do so will result in Claim Rejection.

Signature		Date	dd/mm/yyyy

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