

INTIMATION FORM
(TO BE FILLED IN BY THE INSURED)

POLICY DETAILS

(To be filled in block letters)

a) Proposer Name:

b) Patient Name:

c) Universal Sampo Health Serve Card No:

d) Employee No:

e) Corporate Name (if applicable):

f) Policy No:

g) Contact No:

h) Mobile No:

i) Email ID:

j) Contact Details of Attending Relative:

SECTION A

HOSPITALIZATION DETAILS

a) Hospital Name:

b) Hospital Address:

c) City: d) State:

e) Pin Code:

f) Contact No:

g) Email ID:

h) Date of Admission:

i) Date of Discharge:

j) Claim Intimation: ☐ Cashless ☐ Reimbursement

k) Estimated Amount: ₹

l) Ailment:

SECTION B

Date:

Place:

Authorized Signatory: