

# Group Employee Insurance Claim Form

This **group employee insurance claim form sample** provides a clear and organized template to streamline the process of filing insurance claims. It ensures accurate data collection and simplifies verification for both employers and insurance providers. Utilizing this form helps expedite claim approvals and improves overall employee satisfaction.

A. Employee Details

Full Name:

Employee ID:

Department:

Contact Number:

Email Address:

B. Insurance Policy Details

Policy Number:

Insurance Provider:

Type of Coverage:

Medical

C. Claim Details

Claim Amount (â‚¬):

Date of Incident:

Description of Claim:

Briefly describe the nature of the claim.

Hospital/Clinic Name (if applicable):

D. List of Attached Documents

Document	Attached (Yes/No)
Medical Reports	<input type="checkbox"/>
Hospital Bills	<input type="checkbox"/>

Prescription	<input type="checkbox"/>
Other (specify below)	<input type="checkbox"/>

Other Documents (please specify):

### E. Declaration

I hereby declare that the information given above is true and complete to the best of my knowledge. I understand that any false declaration may lead to rejection of my claim.

Employee Signature:

Date:

### F. Employer/HR Verification

HR/Manager Name:

Signature:

Date:

Submit Claim