

Complaint Registration Form

* Please complete in BLOCK CAPITALS and give a definite answer to each question
 * Use a separate paper if the space provided for the answer is not enough

Insured Details

Please provide contact details.

Name of Complainant :			
Name of patient (where applicable) :			
Date of complaint			
Contact Information :	PO Box :	City :	Country :
	Tel :		M ob :
	Email ID :		

Policy Details

Please provide the policy detail. Please ensure correctness of the details provided.

Policy No :	Certificate / Member No :
Policy Type :	
Insurance Company Name :	

Detail of the complaint

Please give exact description of the complaint. If there are any documents supporting the complaint, please provide as attachments

Description of the complaint	
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For Office Use Only

Complaint Ref No :

Signature	Date	Place
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***PLEASE SEND THIS FORM TO : info@bhigroup.ae