

# Health Insurance Premium Receipt

Receipt No. \_\_\_\_\_

Date \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

Policy Number \_\_\_\_\_

Address \_\_\_\_\_

Contact Number \_\_\_\_\_

Premium Period	Amount Paid	Payment Mode	Payment Date

Remarks \_\_\_\_\_

\_\_\_\_\_

Signature of Policy Holder

\_\_\_\_\_

Authorized Signatory