REQUEST FOR REFUND

Date of Refund Request: _____

Principal Member: _____

Patient's Name: _____

Company Name: _____

Member No: _____

Reason for Refund:

_____
_____
_____
_____

Amount to be refunded: _____

Original supporting documents provided: ☐

Principal Member Signature: _____

Contact Number: _____

Human Resources Manager Signature: _____

Received at Prudential By: _____

Date Received: _____

Bank Details (Principal Member)

Account Name

_____

Account Number

_____

Bank Name

_____

Branch Name

_____

Kindly ensure the following are attached for the refund to be paid:

Original receipts and any other supporting documents

All invoices (specifying type of tests/services provided & medication prescribed) from the Healthcare Provider

Breakdown of the total cost.