Deductible	Amount	(%)	
Diagnostic & Treatment Services For Dental	0.00	0.00	Patient Mobile No:
& Gum			*
Gp	50.00	20.00	Purpose of patient visit *
Gp Maternity	0.00	10.00	
Hearing & Vision Aids	0.00	0.00	Physiotherapy session
Inpatient Maternity	0.00	10.00	
Lab	0.00	0.00	nebulization
Medicine	0.00	10.00	
Op Ante-Natal Services	0.00	10.00	Others
Outpatient Maternity	0.00	10.00	In Case Of OTHERS, Please specify the reason/s in Remark
Physiotherapy	0.00	0.00	Remarks
Procedure	50.00	20.00	
Radiology	0.00	0.00	
Spl	50.00	20.00	
Spl Maternity	0.00	10.00	