PE/SH /FO/SE/01

SURGICAL AND HOSPITAL EXPENSES INSURANCE CLAIM FORM

Item No.

Policy No : …… Date of Payment of Last Premium : .....

INSURED

1. Name (in full) …… Age ……
2. Occupation (describe fully) ……
3. Address ……
4. Telephone No……

DEPENDANT - (Subject in respect of whom clam is made)

1. Name (in full) ……
2. Relationship ……

INJURY- Please State

1. Date and place of Accident ……
2. Precisely how the Accident Occurred ……
3. Nature and Extent of injuries ……

ILLNESS - Please State

1. Nature of Description of illness ……
2. Date of Commencement of illness……
3. Date of first consultation regarding this ailment ……
4. Name & the address of doctor who was first consulted ……

PERIOD OF HOSPITALIZATION

From …… **To ……**

GENERAL INFORMATION 1. Have you ever had the same illness before? If so, give particulars and date.	
2. Have you during the past five years had any illness or accident necessitating Medical attention? If so, give full particulars.	
3. Have you previously suffered from sickness, accident, injury which has given rise to a claim on this Corporation or any other insurer or upon any Benefit / Society or Fund? if so give full particulars	
4. Are any claims pending or are you intitled to claim upon any other Insurer, Society or fund in respect of any illness or any injury suffered by you?	

5. If you are undergoing treatment for the injury of illness to which this claim relates, please state a) Nature of illness b) Nature of treatment c) Name of hospital concerned if any d) Name of any Consulting Specialist Whose recommended treatment you or have been receiving giving details of the treatment concerned and other Specialist Services received.	
6. PLEASE FORWARD a) Original receipts for all payments b) Original detail bill c) Diagnosis card d) Fully completed claim form	

I HEREBY DECLARE that I have received the injuries above described and suffering from illness as above described and I claim reimbursement under the above policy in respect thereof I hereby warrant that the above statements and facts are true and that I have not withheld from the Corporation any material information connected with this claim.

Witness …… (Signature) ……..
Data …….. Date ……

TO BE COMPLETED BY THE PATIENT'S GENERAL PRACTITIONER/SURGEON

(a) Name of patient (in full) .....
(b) Investigation or treatment .....
(C) General practitioner by whom referred .....
(d) Diagnosis of disease .....
(e) Details of treatment or operation and prognosis .....
.....
() Was the onest of illness acute, sub acute or chronic? .....
(g) For how long would the patient have suffered from these symptoms and signs? .....
(h) Period of hospitalization .....
Date of admission ..... Date of discharge .....
(i) State approximately when, in your opinion the ailment could have BEGUN or been CONTRACTED by the patient .....

I certify that I am the General Practitioner/Surgeon of the patient of the referred to above, and that I approved the services for which the claim is made.

Name of .....
Qualifications practitioner/Surgeon .....
Address .....
T.phone No. ……

Date ……

.....
Signature of the practitioner/surgeon/specialist with the rubber stamp. Who attended on this patient for this ailment.