

HOSPITALIZATION INSURANCE CLAIM

This form is issued without admission of liability and must be completed and returned after completion of treatment. No claim can be considered unless the Medical Certificate overleaf is completed at the policyholder's expense.

1. POLICYHOLDER _____ POLICY NO. _____

ADDRESS _____ TEL: OFFICE _____

RESIDENCE _____

2. PERSON UNDER TREATMENT _____

BUSINESS / OCCUPATION _____ DATE OF BIRTH _____

<p>3. (a) Nature of illness / injury (b) When did it commence ?</p>	
<p>4. Name and address of the Doctor whom she / he first consulted</p>	
<p>5. Name and address of her / his usual Doctor</p>	
<p>6. Has she / he ever suffered before from the illness / injury in respect of which you are claiming ?</p>	
<p>7. Have you previously claimed or received compensation under an Accident or Hospitalisation Policy ? If so, give particulars</p>	
<p>8. (a) Are you insured elsewhere ? (b) If so, give the names of Company / Insurer and amounts you are entitled to claim</p>	

I claim the amount of \$ _____ being expenses incurred by me for treatment in accordance with the particulars above and receipts bills attached.

I / We hereby declare that the foregoing particulars are true and correct, that no information has been withheld and that the amount claimed is an accurate assessment of the loss suffered.

Date

Signature of Policyholder

ATTENDING PHYSICIAN'S MEDICAL REPORT

Note : I) The Insured Person / Claimant must obtain at his/her own expense the Medical Report from Attending Physician / Surgeon
 II) This report must be completed by the Attending Physician / Surgeon whose replies should be as full as possible

1.	Name of Patient :		
2.	Admission Period :		
3.	Final Diagnosis (Based on ICD, 1975 Revision, WHO) of illness or extent of injury		
4.	What is the cause of the illness / injury ?		
5.	Please specify the approximate date of discovery of the illness / injury:		
6.	How long has the illness / injury been existing prior to consulting you ?		
7.	When did the patient first consult you for this condition ?		
8.	Did the patient has any symptoms prior to consulting you ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not to my knowledge If YES, please indicate the nature of symptoms and date the symptoms first started: Doctor(s) previously consulted by the patient for the above condition:		
	<u>Name</u>	<u>Date</u>	<u>Name of Clinic / Hospital</u>
1)	_____	_____	_____
2)	_____	_____	_____
9.	Describe the surgical procedures / treatment rendered. If no surgery was performed, please state the treatment / medication given. Date of surgical procedures / treatment rendered: _____		
10.	Is the patient still under your care for this condition ? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, please give the date service was terminated, and furnish name and address of doctor if the patient has been referred to another doctor for follow-up:		
11.	What is the prognosis of this illness ?		
12.	Is this treatment related to the following :		
	(a) Pregnancy or Childbirth ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	(b) Abortion or miscarriage ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	(c) Infertility or sub-fertility condition ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	(d) Sexually transmitted disease ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	(e) Congenital anomaly; a physical defect at birth; a genetic condition ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	(f) Refractive error of the eye ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	(g) Dental surgery / treatment ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	(h) Mental or nervous disorder ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	(i) Self inflicted injury ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	(j) Cosmetic Surgery ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13.	(a) Is this condition related to any accident or injury ? <input type="checkbox"/> Yes <input type="checkbox"/> No (b) If this a work related illness or accident ? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES to any of the above (a) or (b), please provide the date of the accident and explain the extent of the injury sustained.		

I hereby certify that the above patient had been examined and treated by me for the above * injuries / illness and the statement given above present my opinion of his / her condition.

Signature of Physician / Surgeon

Date

Name / Designation

Name and Address of Clinic / Hospital

* to delete as applicable