ISO 9001 : 2008

Certified

JANASHAKTHI INSURANCE PLC

Life Office : No.75, Kumaran Ratnam Road, Colombo-02. Tel : 0112 636 636

HOSPITALIZATION CLAIM FORM

Policy No.	Date of Claim
Claim No.	Date of Notification

A. POLICY HOLDER

A.1 Name and Address of the Policy Holder/Member : ……

……

B. PATIENT / INJURED PERSON

B.1 Name and Address of Patient / Injured Person : ……...

……

B.2 Employment/Occupation at the time of claim : ……

B.3 Age : …… B.4 Telephone No : ……..

C. ILLNESS / INJURY

C.1 Date of commencement of illness / Date and place of accident : ……...

……

C.2 Nature and the circumstances of illness / how did accident occur? ……

……

C.3 Symptoms of illness / Nature of injuries : ……..

……....

C.4 Have you / She / he / suffered previously from similar illness / injury to the same part?.....

If yes please give details : ……

……

C.5 Are you still undergoing treatment for this illness / injury?

……

If so, please give details : ……

D. MEDICAL PRACTITIONER

D.1 Name and address of Specialist / Surgeon in attendance : ……

……

E. Are you under any other insurance or receiving compensation from any other source? ……..

If yes please give details……

……....

F. DECLARATION

I / We hereby declare that the above stated facts and statements are true to the best of my / our knowledge and belief and that I / We have not withheld from Janashakthi Insurance PLC, any material information connected with this claim. Further, to obtain information regarding the state of my health or any other information or any report that may be required from my employer or from any hospital / s or medical attendants who treated me, or any other institution.

…….. ……

Date Signature of Insured

NOTES :

1. It is important that the Doctor's Report should be completed by Specialist / Consultant.
2. If you are claiming for re-imbursement of Medical or other expenses full details and evidence must be provided including the documents marked.

- ☐ Diagnosis Ticket
- ☐ Original Hospital Bills & receipts Doctor's Prescriptions
- ☐ Past Medical History Reports, including the 1st channeling slip

Further documentary evidence may be requested or considered necessary by the Company.

Your Account Number :	
Name & the Branch of the Bank : ……	
Mobile Number :	

(Please provide a copy of the pass book/ bank statements or any evidence of your bank account with a copy of NIC)

DOCTOR'S REPORT

(1) Name of Patient : ……

(2) When were you first consulted in this connection? ……

(3) When, in your opinion or from your knowledge could this ailment have begun or been contracted? ……

……

(4) Your diagnosis of disease : ……

(5) Details of treatment or Operation : ……

(6) Your prognosis for a complete recovery : ……

(7) Period of hospitalization From : ……. To : ……

(8) Is the patient suffering from any other ailment such as Diabetes, Hypertension, Bronchial Asthma? If so

(i) Please specify the ailment …….

(ii) Date of Diagnosis of the ailment …….

(9) Please give details of any other past medical history if any ……...

……

Date : ……. ……

Signature of the Surgeon/Consultant

Name of Surgeon/Consultant : ……

Address : ……..

Qualifications (Official Seal) : ……..

FOR OFFICIAL USE ONLY	
Total amount available at of claim	Rs.
Total amount now payable	Rs.
Balance available for current year	Rs.
Details of previous claims (date & name of claimant)	

Amended on 24/08/2016