JANASHAKTHI INSURANCE PLC

1st Floor, Bishop's Gate Building, #338, T B Jayah Mawatha, Colombo 10. TP.0112 636 636.



HOSPITALIZATION CLAIM FORM

Policy No.	
National Identity Card No.(Member/Employee)	

A. POLICY HOLDER

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

Member No.

B. PATIENT / INJURED PERSON

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

..... NIC No.: ….....

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

Name/address & contact details of the Employer: ……..

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 treatement for this illness / injury ?

If so, please give details : .....

....

D. MEDICAL PRACTITIONER

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

.....

E.

E.1. 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.

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.

i. Diagnosis Ticket ☐

ii. Original Hospital Bills & receipts Doctor`s Prescriptions ☐

iii. Past Medical History Reports, including the 1st channeling slip ☐

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

Your Account Number : .....

Name & the Branch of the Bank : .....

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 hospitalisation 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 date of claim	Rs.
Total amount now payable	Rs.
Balance available for current year	Rs.
Details of previous claims (date & name of claimant)	