HNB Assurance PLC (PQ 108)

No.10, R. A. De Mel Mawatha, Colombo 03

"SESATHA" MEDICAL EXPENCES INSURANCE CLAIM FORM

All Questions must be fully answered

Policy No : ……………………………………………… **Claim No :** ……………………………………………………

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01. INSURED

Name (In full) : ………

Address : ……………………………………………………………………… **Phone No :** ……………………………………

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02. PERSON IN RESPECT OF WHOM CLAIM IS MADE

Name : ……………………………………………………………………………………………… **Age:** ……………

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03. INJURY

a.) Date and Place of Accident……………………………………………………………………………………………

b.) Precisely how the Accident Occurred……………………………………………………………………………………

c.) Nature and extent of Injuries……………………………………………………………………………………………

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04. ILLNESS

a.) Nature of Illness……………………………………………………………………………………………………

b.) Date of Commencement………………………………………………………………………………………………

c.) Has the patient previously suffered from similar Illness? Yes / No……………………………………………………
If yes, please give details………………………………………………………………………………………………

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05. PERIOD OF DISABILITY

a.) From Engaging Or Attending To Usual Business As A

Result of the injury/ Illness From :…………………………………………………………………**To:**……………………………
Or
b.) Confined to house as a result of the injury From :………………………………………………**To:**……………………………

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06. HOSPITALISATION

If you have undergone or are undergoing treatment for the injury or illness to which this claim relates please state:

a.) Nature of Illness………

b.) Nature of Treatment…………………………………………………………………………………………………….

c.) Name of Hospital……..

d.) Names of Consulting Specialists whose recommended treatment you are or have been receiving, giving details of the treatment concerned.
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…….….
………

e.) Hospitalization charges including Nursing Home Charges, Surgeon's fees, Operation Theater charges, Expenses for X- ray, ECG, Laboratory Tests, Medicines and Drugs, Fees paid to Medical Practitioner and all other Expenses whilst in hospital.
Rs: ……………………………………………

07. GENERAL INFORMATION:

a.) Name and address of the medical Practitioner who is, or has been attending on you, for this illness or injury.	
b.) Is he your usual medical Attendant	
c.) Have you, ever had the same illness before? If so, give.	
d.) Have you, during the past three years had any illness or accident necessitating medical Attention? If so, Give full Particulars?	
e.) Have you, Previously suffered from any sickness or accident injury which has given rise to a claim on this company or any other insurer?	
f.) Are you entitled to claim upon any other Insurer, Society or fund in respect of this illness or injury?	

I/ We declare that the particulars given above are true and correct to the best of my/our Knowledge and belief and that I/We have not withheld from the company any material information connected with this claim.

Date:…………………………………………… Signature:…………………………………

DOCTOR'S REPORT

a.) Name of the Patient:……………………………………………………………………………………………………….

b.) Condition that necessitated investigation or treatment:……………………………………………………………

c.) General Practitioner by whom referred:…………………………………………………………………………………

d.) Diagnosis of the Disease:…………………………………………………………………………………………......

e.) Details of treatment or operation and prognosis:…………………………………………………………………

f.) Please state briefly the history or injury of ailment:……………………………………………………………..

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g.) Period unable to attend to usual business / confined to House: From :……………………… To :………………………..

h.) State approximately when, in your opinion the ailment could have BEGUN or been CONTRACTED by the patient?

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i.) How much longer do you feel such disablement will continue? From :………………………… To :………………………
Has the patient to your Knowledge any other disease or physical defect? Yes / No
If * Yes,
What is the nature? ……………………………………………………………………………….Date:………………………

Name : ……………………………………………………………………….. **Signature:** ……………………………………

Qualification : ………………………………………………………………………..

Address : ………………………………………………………………………..

Telephone : ………………………………………………………………………..