PE/SH/FO/SE/01

Sri Lanka Insurance
Corporation Ltd

SURGICAL AND HOSPITAL EXPENSES INSURANCE CLAIM FORM

Item No

Policy No:..... Date of payment of last Premium.....

LIFE INSURANCE:

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

DEPENDANT – (Subject in respect of whom claim 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.....

ILLNSS – 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 claim pending or are you entitled to claim Upon any other Insurer, Society or fund in respect of Any illness or any injury suffered by you ?	

General Accident Department
10th , FLOOR, 21,VAUXHALL STREET, COLOMBO - 02

5. If you 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 concerned if any (d) Name of any Consulting Specialists 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) Full 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).....
Date..... Date.....

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

(a) Name of patient (in full).....
(b) Condition that necessitated investigation or treatment.....
(c) General practitioner by whom referred.....
(d) Diagnosis of disease .....
(e) Details of treatment or operation and prognosis.....
.....
(f) 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

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 this claim is made

Date .....

.....
Signature of the practitioner/Surgeon/specialist
who attended on this patient for this ailment

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

To be completed by surgeon all cases as surgical as surgical treatment