Without Prejudice

WhatsApp / Viber number +94 765148892

SOFTLOGIC LIFE HOSPITALIZATION CLAIM FORM

Please complete this form using BLOCK CAPITALS throughout part 1, from sub section A to G and the below declaration must be completed by the life assured. The hospital treatment certification must be completed by the doctor who treated the patient. All questions need to be clearly answered.

Please delete whichever is inapplicable

Policy Number	

Part I - To be completed by the life assured

Section A - Details of the Life Assured

01. Name with initials of the life assured			
02. Mailing address			
03. Contact number		04. Email	
05. Occupation			

Section B - Details of the person hospitalized - (As indicated in the policy to be completed by life assured/policyholder)

01. Full name					
02. Date of birth		03. Gender		04. Relationship to life assured	
05. Occupation		06. Name of the hospital			

Section C - Reason for admission

01. Admission complaint / Symptoms	02. Date of commencement of symptoms	03. Pre-hospitalization treatments received			
		Not treated	E.T.U. Treatment	O.P.D Treatment	Treatment at Clinic

04. Have you or he/she ever suffered from the same illness before? if yes, please provide the first diagnosed date?

Section D - Claimant's declaration

I/We/My child/Spouse (as shown in section B.01) received medical treatment at (as shown in section B.06). I attach herewith the relevant original bills . Further hereby give my consent to obtain any information and particulars related to my/my spouses / my child's illness/disease from any hospital authority/any employer /insurer or any other source. Also, I hereby warrant that the above statements and facts are true and not withholding any material fact in connection to this claim and agree that Softlogic Life Insurance PLC reserves the rights to terminate the benefits if such information found fraudulent, manipulated or hidden.

E - An incomplete claim form could lead to rejection of your claim

Customer checklist before informing of the discharge

- Completed claim form
  - Customer's signature
  - Consultant's signature and seal (Medical officer signature & hospital's seal, if consultant is not available)
- Diagnosis card
  - Consultants signature and seal (Medical officer signature & hospital's seal, if consultant is not available)
- Final Bill / Other payment receipts (with breakdown)
- Laboratory & pharmacy medicine breakup
- Police report in the event of an accident
- Past medical reports / Diagnosis ticket

* Please WhatsApp and Viber the check list documents to expedite your claim

Section F - Other information			
Name of other insurance/s to cover this hospitalization.....			
Policyholder name		Policy number	
Mailing address			

Section G - Bank details for the payment			
01. Account Number of the policyholder		02. Bank & Branch	
I hereby give my consent to deduct Rs. 25.00 of stamp fee if any claim amount is Rs. 25,000 above			

....

Signature of the Life Assured Date

Part II - HOSPITAL TREATMENT CERTIFICATE (TO BE COMPLETED BY THE MEDICAL OFFICER WHO TREATED THE PATIENT)

Section "A" -Please provide the following details from the hospital records & any alternations made by the doctor, full signature has to placed

(a) Name of hospital/nursing home: .....

(b) Age: ..... (c) Date of admission: ..... (d) Date of discharge: .....

(e) Ward number: ..... (f) BHT number: .....

(g) Was any period spent in an Intensive Care Unit, if so for how many days?.....From.....To.....

(h) Complaints at the time of admission .....

(I) If accident, date and nature of the accident: .....

(j) What was the diagnosis? .....

(k) Exact date of diagnosis? .....

(l) Date of first consultation regarding this ailment? .....

(m) Name and address of the doctor (1st consultation) .....

(n) For how long would the patient have suffered from the above ailments .....

Section "B" – Past Medical History

Disease		Duration
1.Diabetes mellitus	☐	.....
2.Hypertension	☐	.....
3.Coronary artery disease	☐	.....
4.Dyslipidemia	☐	.....
5.Bronchial asthma	☐	.....
6.Stroke	☐	.....
7.Other	☐	.....

Section "C" – Past Surgical History

Signature of the Medical Practitioner

Name: .....

Qualification & Designation: .....

SLMC Registration No.....

Name & Address of Hospital: .....

(Official rubber stamp giving these details to be placed)