LOLC Life Assurance Limited

(Company Registration No PB-3807)
No 481, T B Jaya Mawatha, Colombo 10. Sri Lanka.
Tel: 011 5 889488 Fax: 011 5931881
Email: lifeclaims@lolclife.com Website: www.lolclife.com

Hospitalization Claim Form

Policy Number :	**Claim Date :**
Claim No :	**Intimation Date :**

A. Policy Holder

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

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B. Patient

B.1 Name and Address of the Patient: ……

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B.2 Details of Occupation and Nature of Duties at the time of Claim: …… B.3 Age: …… B.4 Telephone No: ……

C. Illness / Injury

C.1 Date of Illness (first diagnosis): …… C.2 Date & Place of Accident: ……

C.3 Date of Admission: …… C.4 Date of Discharge: ……

C.5 Symptoms of Illness: …… ….. C.6 Details of Accident :……

C.7 Primary Symptoms of Illness/Injury: ……

C.8 Have you ever been diagnosis/confronted a similar illness / injury: ……
If "Yes", please give details: ……

C.9 Are you still having treatments for the said illness? ……

If "Yes", please give details:……

D. Doctor/Specialist

D.1 Name and address of the Doctor / Specialist / Surgeon who treated you: ……

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E. Details of Bank Account to settle the claim

If you wish to send the claim direct to bank, please provide your bank details (up to Rs. 50,000.00)

E.1 Name of the Bank: …… E.2 Branch: ……

E.3 Account No: …… E.4 Account Holder's Name: ……

E.5 Type of Account: …… (Savings Account / Current Account)

F. **Declaration**

Above statement is true & accurate to the best of my knowledge. Further, I authorize any official representatives of LOLC Life Assurance Limited to obtain any relevant clinical/medical reports from any private or Government Hospital, Clinic, Nursing Home, or sanatorium, if necessary.

Date : …… NIC Number : …… Signature of Policy Holder : ……

Important

Please submit following documents along with this claim form to consider the claim.

1. Duly completed "Doctor's Report" by the Doctor who treated (part II of this claim form)
2. Diagnosis Card
3. Copy of Pass Book (For Direct Bank Transaction)

- Submission of Claim form duly acknowledged by us does not amount to admission of claim.

Next Page

Policy Number -

DOCTOR'S REPORT

(TO BE COMPLETED BY THE MEDICAL OFFICER WHO TREATED THE PATIENT)

1. Name of Patient: ……
2. NIC No : …… 3. BHT No : ……
4. When were you first consulted in this connection? ……
5. Was the onset of the illness acute or chronic? ……
6. For how long would the patent have suffered from these symptoms and sign?

   ……
7. Please give history of the disease or illness?
   (a) Date when such was observed by the patient? ……
   (b) By whom he/she was treated? ……
   (c) By whom the history was reported? ……
8. Your diagnosis of disease: ……
9. Details of treatment or operation: ……
10. Your prognosis for a complete recovery: ……
11. Period of hospitalization

    From: …… To: ……
12. Period spent in an Intensive care Unit,

    From: …… To: ……
13. Is the patient suffering from any other ailment such as Diabetes, Hypertension, Bronchial Asthma, etc.?
    (a) Please specify the ailment: ……
    (b) Date of Diagnosis of the ailment: ……
14. Please give Details of any other past medical history if any: ……

    ……

Date: …… ……

Signature of the Surgeon/Consultant

Name of Surgeon/ Consultant (Official Seal) : ……

Address : ……