UNIVERSAL LIFE

Claim Form

GROUP MEDICAL/HOSPITAL SCHEME

PART A - To be completed by the Insured

Policy No. :..

Insured's Name :...................................... I.D. No..........................

Patient's Name :...................................... Date of Birth..........................

Address :...................................... Telephone No..........................

Description of illness/Accident:..

....

.When did the first symptoms occur?..

Has the patient ever suffered from the same illness before?..

Give names and dates of all the doctors the patient has consulted

1.......................................Date:..........................Tel. No:..........................

2.......................................Date:..........................Tel. No:..........................

What therapy/medicines were prescribed?..

....

Are you entitled to a refund from another fund or organisation and what amount?..

....

DECLARATION

I declare that the above answers are true and correct and I authorise all doctors or institutions who have at any time examined the patient, to supply Universal Life with whatever certificates or information they may request. I further declare that the total amount paid for the above condition according to the receipts enclosed is €..........................

Insured's Signature.. Date..........................

PART B - CLINIC/HOSPITAL EXPENSES (Please enclose origianal payment receipts)

Entry Date:..........................Eit Date:..........................

1. Accommodation:..........................days @ €.......................... €..........................
2. Theater expenses:.. €..........................
3. Anaesthetist:.. €..........................
4. Laboratory tests; x-rays (please enclose results).. €..........................
5. Medicines (Please enclose analytical list).. €..........................
6. Surgeon Fees.. €..........................
7. Other expenses (describe):.. €..........................

Total Expenses.. €..........................

....

Signature & Seal of Clinic/Hospital

Date:..........................

Name:.. Tel. No.:..........................

PART C - DOCTOR'S REPORT

Patient's Name:..Date of Birth:..

Illness ☐ Accident ☐ Symptoms:..

1. Cause of Accident/Illness:..
....
2. Date of first symptoms (if exact date not known give approximately):..
3. When did you first examine the patient regarding this illness? (exact date):..
4. Has the patient been examined for the same or similar condition in the past by another doctor? If yes please give name and date:
....
5. Clinical Results:..
....
....
....
6. Provided there was an accident, have there been any signs of injury on the body which could prove the occurance of the accident? (If yes please give detailed description)
....
....
....
7. Described the therapy which was followed and the medicine/tests prescribed:..
....
....
....
....
8. Diagnosis (detailed)..
....
9. Has the patient recovered? (If not give prognosis)..

Doctor's Fees:..

Date:..

Doctor's Signature:..

Name:..

Specialisation:..

Comments of Company's doctor:..
....
....
....
....

Name:..Signature:..Date:..