



Orient Insurance Ltd (PB 4720)

Head Office 133, New Bullers Road, Colombo 04, Sri Lanka Tel (+94 11) 203 0300

SURGICAL AND HOSPITALISATION EXPENSES CLAIM FORM

It is important that a complete answer be given to every question. If insufficient space is provided for your answers please continue on a separate sheet. When you see Yes/No please tick appropriate box.

INSURED OR POLICY HOLDER.

1. Full Name :

2. Postal Address :

.....

Phone No:

INJURED PERSON

1. Full Name : Age:

2. Postal Address :

.....

Phone No:

3. Name of Patient : Age:

4. Relationship to the employee : (Husband / Wife / Son / Daughter)

INJURY OR ILLNESS

1. Nature of injury or illness :

2. Date of commencement of illness :

3. Name & address of the Doctor attending the injured person :

.....

4. Is he the injured person's usual Doctor:

OTHER INSURANCE & COMPENSATION

1. Are you or the injured person claiming under any other insurance or receiving compensation from any Other source? Yes...../ No.....

2. If Yes, please give details:

DECLARATION

I/We hereby declare that these particulars are true to the best of my/our knowledge and belief.

Injured person's signature: NIC No:, Date:

Note: It is important that a fully qualified and registered medical practitioner should complete the attached Medical Report.

DOCTOR'S DIAGNOSIS
(To be filled by the patient's General practitioner / Physician or Surgeon*)

- a) Name of Patient (in full):
- b) Condition that necessitated investigation or treatment:
- c) General Practitioner by whom referred:
- d) Diagnosis of disease / ailment (USE BLOCK LETTERS):
.....
- e) Is the ailment / sickness a congenital condition? Yes / No
- f) Detail of treatment or operation and prognosis:
.....
.....
- g) Please state briefly the history of injury or ailment:
.....
- h) Period unable to attend to usual business / occupation and / or confined to house
..... from..... to.....
- i) State approximately when, in your opinion the ailment could have BEGUN or been CONTRACTED by the patient
.....
.....

I certify that I am the General Practitioner / Surgeon of the patient referred to above and that I approved the service for which this claim is made.

Date:

.....
Signature of the Practitioner / Physician / Surgeon
(Over the Rubber Stamp)

Name of Practitioner / Surgeon :

Qualification :

Address :
.....

Telephone No :

Fax :

E-mail :

* To be completed by Surgeon in all cases of surgical treatment