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