MEDICAL EXPENSE - CLAIM FORM

SECTION 1 : CLAIMANT STATEMENT
(To be filled by the Claimant)

POLICY PARTICULARS

Name of Company : _____

Name of Employee : _____ **Emp. ID** : _____

Name of Patient : _____ **CNIC # of Patient** : _____

Age of Patient : _____ **Wellness Card No.** : _____

Relationship with Employee : _____ **Policy No.** : _____

DETAILS OF ILLNESS ☐ Pre & Post Hospitalization ☐ OPD ☐ Hospitalization

Date of illness first noticed : _____ **Date of recovery** : _____

Diagnosis : _____

Has the claimant suffered from this illness before? Yes / No **(If yes, please give date(s) and details below)**

_____

_____

_____

TOTAL AMOUNT OF CLAIM ☐ Pre & Post Hospitalization ☐ OPD ☐ Hospitalization

Please list in the column below all expenses claimed and attach original (not photocopies) of all relevant paid receipt supported by relevant prescriptions and discharge summary

Sr. No.	Receipt No.	Date	Name of Expense	Patient's Name	Relationship with Employee	Amount (in PKR)
Total						

DECLARATION BY THE INSURED PERSON & ASSURED

I/We, as a claimant, hereby declare that the information provided in the form are true and complete to the best of my/our knowledge, belief, and record. I also hereby authorize TPL Life Insurance Limited in order to seek information from any doctor, hospital, laboratory, any other organization or person that has any record information or acknowledge of health/treatment and from any other Insurance / Takaful company to which a proposal has any time been made, and the giving of such information.

Employee Signature	Employer Signature with Stamp	Date of Statement

SECTION 2 : PHYSICIAN STATEMENT

(To be filled by the Attending Physician - IN CASE OF HOSPITALIZATION)

DETAILS OF HOSPITAL

Name of Hospital attended : _____

Name of medical practitioner consulted : _____

Period of confinement : **From :** _____ **To :** _____

Were any medicines prescribed : Yes / No **(If yes, please list the medicines prescribed and administered below)**

_____

_____

_____

DECLARATION BY THE ATTENDING PHYSICIAN

I confirm having treated Mr/Mrs/Miss:_____ between the dates_____ and _____ and that the details shown on this form are consistent with my own knowledge of the patient.

Signature of Attending Physician with stamp	Date of Statement

***Note:**

1) Mandatory documents which needs to be submitted with claim form are as follows:

a) Proper itemized hospital original bills

b) Discharge Card / Summary

c) Support / Evidence (Reports, prescription etc.)

d) Attach valid copy of CNIC and Wellness Card

2) Form needs to be completed in all aspects

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