EFU LIFE ASSURANCE LTD.

HOSPITALIZATION / MEDICAL EXPENSE CLAIM FORM

POLICY #

1. Name of Group

2. Name of Member

3. Date of Birth D D M M Y Y

4. CNIC No. – –

6. CNIC Issue Date D D M M Y Y

5. Contact

7. Account Details

Bank Name

IBAN Number (24 Digits)

8. Details of Incident / Event _____

9. Date D D M M Y Y

10. Cause

11. Brief Description of Event _____

12. What Were the Presenting Complaints _____

Hospitalization Required? Yes ☐ No ☐ If Yes Kindly Fill in the Details

Name of Hospital	Date of Admission	Date of Discharge	Days of ICU Confinement	Name of Operation / Surgery	Date of Operation
1)	D D M M Y Y	D D M M Y Y			D D M M Y Y
2)	D D M M Y Y	D D M M Y Y			D D M M Y Y
3)	D D M M Y Y	D D M M Y Y			D D M M Y Y
4)	D D M M Y Y	D D M M Y Y			D D M M Y Y
5)	D D M M Y Y	D D M M Y Y			D D M M Y Y

13. Name of Physician / Surgeon

14. Basic Documents Required for Assessment (Please Check & Attach Documents)

- ☐ Admission & Discharge Summary
- ☐ Hospital / Medical Bills
- ☐ Hospital Treatment & Medical Records
- ☐ CNIC
- ☐ Claim Form

DECLARATION

I hereby certify that my answers to the foregoing are correct to the best of khowledge and belief.

Signature of the Member

Date D D M M Y Y

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