Better. Simple. Life.

CLAIM FORM
(In-Patient)

Part I - TO BE COMPLETED BY PATIENT/MEMBER

Full name of patient: _____

Policy No. _____ Member No. _____

ID Card No. _____ Date of Birth _____

Full name of member (if patient is a dependant) _____

Member's employer name _____

When did the present sickness start? _____

Have you suffered from this sickness in the past?
If yes, when did it start and how frequent is it? _____

Part II - TO BE COMPLETED BY ADMITTING/ATTENDING DOCTOR

Hospital Name _____

Date of Admission _____ Date Discharged _____

Attending Doctor's Name _____

Tel: _____ Fax: _____

Final Diagnosis _____

Consultant Referred to _____ Speciality _____

Doctor's Signature _____

DECLARATION

I understand that any incorrect statement or the non-diclosure of any material information in this form may jeopardise my claim. I warrant that the answers in this form are true, correct and complete and I acknowledge that such answers are all material. I hereby authorise the hospital, medical or dental practitioners who have treated me or any of my dependants to disclose to the Company the records relating to such current or previous hospitalisations / medical treatment and to allow the Company to receive extracts from such records and undertake to assist in obtaining such information.

Member's Signature _____ Date _____

UAP Insurance Company Limited
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