

**SURGICAL & HOSPITALISATION TAKAFUL CLAIM FORM**

**CERTIFICATE HOLDERS DETAILS**

NAME : ..... / COMPANY NAME .....

CERTIFICATE NO : ..... CONTACT NO. ....

N I C NO : ..... MEMBERSHIP NO : .....

**PATIENT'S DETAILS**

NAME : .....

MEMBERSHIP NO : .....

**DETAILS OF ILLNESS / ACCIDENT / HOSPITALISATION**

NATURE OF ILLNESS : .....

COMMENCEMENT DATE OF ILLNESS : 

DD	MM	YY
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HAVE YOU PREVIOUSLY SUFFERED FROM SIMILAR ILLNESS 

YES	NO
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 IF YES PLEASE GIVE DETAILS

**GENERAL INFORMATION**

IS A CLAIM BEING MADE UNDER ANY OTHER CERTIFICATE OR CERTIFICATES IN RESPECT OF THIS INJURY OR ILLNESS OR IS COMPENSATION BEING RECEIVED FROM ANY OTHER SOURCE ?

YES	NO
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 IF YES PLEASE GIVE DETAILS

PERIOD OF HOSPITALISATION FROM 

DD	MM	YY
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 TO 

DD	MM	YY
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TOTAL HOSPITAL EXPENSES Rs. ....

THERE HAS BEEN NO SUPPRESSION OF FACTS AND TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION ARE TRUE

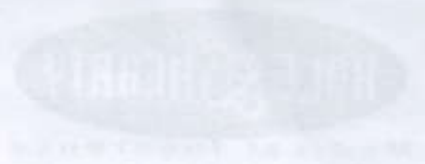
**DOCUMENTS ATTACHED WITH THIS FORM**

YES	NO	ORIGINAL & FINAL BILL FROM THE HOSPITAL
YES	NO	ORIGINAL RECEIPTS
YES	NO	ORIGINAL DIAGNOSIS CARD
YES	NO	OTHER .....
		.....

SIGNATURE OF CERTIFICATE HOLDER

DATE 

DD	MM	YY
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**DOCTOR'S MEDICAL REPORT**

PATIENT'S NAME : .....

ILLNESS FOR WHICH TREATMENT WAS GIVEN : .....

WHEN IN YOUR OPINION COULD THE ILLNESS  
HAVE BEEN CONTRACTED OR BEGUN : .....

WHEN WERE YOU FIRST CONSULTED FOR  
THE ILLNESS ? .....

HAS THE PATIENT PREVIOUSLY  
SUFFERED FROM THIS ILLNESS ?

YES	NO
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IF YES, PLEASE GIVE DETAILS

.....  
.....  
.....

HAS THE PATIENT TO YOUR KNOWLEDGE ANY  
OTHER ILLNESS ?

YES	NO
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IF YES, PLEASE GIVE DETAILS

.....  
.....  
.....

**DOCTOR'S INFORMATION**

NAME .....

DD	MM	YY
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**DOCTOR'S SEAL & SIGNATURE (MANDATORY)**

**DATE**