HOSPITALIZATION CLAIM FORM

Group Life

SCHEME DETAILS

Scheme name: _____

EMPLOYEE DETAILS

Name: _____

Identity Number: _____ Date of Birth: D D M M Y Y Y Y

Signature_____ Date: D D M M Y Y Y Y

HOSPITALIZATION DETAILS (TO BE FILLED BY THE DOCTOR):

Hospital Name: _____

Date of Incident: D D M M Y Y Y Y

Date of Admission: D D M M Y Y Y Y

Date of Discharge: D D M M Y Y Y Y

Name of Attending Doctor: _____

Signature_____ Date: D D M M Y Y Y Y

Hospital Stamp: _____

PAYMENT DETAILS (TO BE FILLED BY THE EMPLOYER):

Payee Name: _____ Bank Name: _____

Branch: _____ Account Number: _____

Company Stamp: _____

Cannon Life Assurance (K) Limited

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