Ceylinco Life Insurance Limited, Ceylinco Life Tower, 106 Havelock Road, Colombo 5 Co. Reg. No. PB5183 Tel:(011) 2461461 Email: service@ceylife.lk Web: www.ceylincolife.com

CLAIMANT'S STATEMENT

To be completed by the Claimant

A. Basic Details

a. Policy Number : .....

b. Name of the Claimant / Owner: .....

c. Address :.....

.....

B. Insurance history

a. Currently are you covered by any other health insurance: Yes / No

b. If Yes, please provide the below details

   a. Company Name : .....

   b. Policy number : .....

   c. Sum Assured : .....

c. Have you been hospitalised in the last 4 years or since inception of this contract : Yes / No
If Yes, please provide details
.....

d. Do you have any hospitalization bill which has not been reimbursed from this Company or any other Insurance Company (If so, please state the date of hospitalization, the reason for non-submission, name of the company and policy number)
.....
.....
.....

Have you been investigated, diagnosed or suffering from any illness prior to this hospitalization? If yes, Please provide details
.....
.....

C. Details of Insured person hospitalized:

a. Name of the Life Assured: .....

b. Relationship to Proposer: Self / Spouse / Child / Father / Mother / Other

c. Date of Birth : _ _ / _ _ / _ _ _ _

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d. Gender : Male / Female
e. Occupation : Service / Self Employed / Homemaker / Student / Retired /
Others : .....
f. Telephone No : .....
g. Email : .....

D. Details of Hospitalization

a. BHT Number : .....
b. Name and address of the Hospital: .....
c. Room category: Day care / Single Occupancy / Twin Sharing / 3 or more beds per room.
d. Hospitalization due Sickness ☐ Accident ☐ Maternity ☐
e. Date of sickness / Accident / Date of Delivery : __/__/____
f. Date of Admission : __/__/____ Time: __/__
g. Date of Discharge : __/__/____ Time: __/__
h. If injury, give cause: Self Inflicted / Road Traffic Injury / Substance abuse / Alcohol Consumption
   i. If Medical Legal : Yes / No
   ii. Reported to police : Yes / No
   iii. MLC Report & Police FIR attached: Yes / No
i. System of Medicine : Allopathic / Other system of Medicine.

E. Details for Claim:

a. Details of treatment expenses:

i. Pre-Hospitalisation Expenses : LKR .....
ii. Hospitalisation Expenses : LKR .....
iii. Post-Hospitalisation Expenses : LKR .....
iv. Ambulance Charges : LKR .....
v. Others : LKR .....
Total : LKR .....

a) Pre-Hospitalisation Period in days : .....
b) Post-Hospitalisation Period in days : .....

b. Claim for Domiciliary Hospitalization : Yes / No

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Claim documents submitted - check list

i. Duly filled and signed claim form
ii. Hospital main bill
iii. Hospital bill payment receipt
iv. Hospital break up bill
v. Pharmacy bill
vi. ECG
vii. Investigation Reports
viii. Copy of intimation letter, if any
ix. Hospital discharge summary
x. Operation theater notes
xi. Doctors request for investigation
xii. Doctor's Prescription
xiii. Others

F. Details of Bills enclosed:

SL	Bill No	Date	Issued by	Towards	Amount in LKR

I hereby declare that the above facts and statements are true to the best of my knowledge and belief and that I have not withheld any material information connected to this claim. I consent to the Company seeking information from any medical practitioner, hospital or clinic or from any insurance company or organization in connection with this claim and I authorize the giving of such information.

....

Signature of the Claimant Date