



Claim Form

IMPORTANT INSTRUCTIONS: (please read them first)

- I- In order for us to provide fast and efficient service, please complete the Form accurately in 'CAPITAL LETTERS'. Photocopies of this form can also be used.
- II- Filled forms should be sent to: Claims Department, EFU Life Assurance Ltd -Health Office: 37-K, Block-6, PECHS, Karachi within **30 days** of the expense incurred date. Please attach the following with the form:
- Proper itemized bill(s) and payment receipt(s) as highlighted below. These should be issued on the official bill/receipt book of the Hospital/Physician/Surgeon/Pharmacy/Laboratory.

Proper hospital bill in original highlighting type of accommodation used (room type) and break up of total bill according to:
① Room charges ② Lab tests and Radiology Charges ③ Consultation charges ④ Surgeon's fee with details (if any)
⑤ Operation Theatre Charges (if any) ⑥ Anesthesia charges (if any) ⑦ Medicines (used during hospitalization)
⑧ Other miscellaneous medical expenses like blood & oxygen, etc.
 - Laboratory, or Radiology reports along with doctor's reference for the same.
 - Itemized bill(s) of medicines purchased supported by Physician's prescription specifying the quantity and respective dosage.
 - Hospital discharge summary / Clinical Summary (in case of Hospitalization).
 - Copy of Birth Certificate (in case of delivery/child birth)
- III- If you have any difficulties filling this form, please call our Call Centre 111-HELP-000 (111-4357-00). Please provide the following requested details to facilitate the processing of your approved claim via direct bank transfer.

To Be Completed by the Employee / Policy Holder:

Name of the Policy Holder:	<input type="text"/>	Policy Number:	<input type="text"/>
Name of the Employee:	<input type="text"/>	Cert. Id:	<input type="text"/>
Name of Patient:	<input type="text"/>	Total Amount Claimed:	<input type="text"/> Rs.
Date of Birth:	<input type="text"/>	Relationship to the Employee:	<input type="text"/>
Bank:	<input type="text"/>	CNIC Number (if any):	<input type="text"/>
Branch:	<input type="text"/>	Department:	<input type="text"/>
A/C. No:	<input type="text"/>	Contact No:	<input type="text"/>
		Email:	<input type="text"/>

Detail of New Born (s) in Case of Maternity Claim:

Date of Birth:	<input type="text"/>	Name:	<input type="text"/>	Gender:	<input type="text"/>
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Declaration / Authorization:

I hereby certify that all answers, and all documents submitted with the claim form are complete and true. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any company, institution or any other person who has any record or information about me and/or of my family members to provide EFU Life Assurance Ltd. with the information, including copies of their records with reference to any sickness or accident, any treatment, examination, advice or hospitalization. Any photocopy of this declaration / authorization shall be taken as the original copy.

Signature of Patient
(if 18 years or above, otherwise signature of the employee)

Signature & Seal of the Employer
(For Corporate Schemes only)

Date

In case of Hospitalization:

Emergency Treatment or Elective? Was pre-authorization taken? Yes No
Date of Admission: Date of Discharge:

Is the patient entitled to any other benefit or compensation from any other source whatsoever? If so name the companies or association, or other source, and give amount of benefit payable by each:

This portion must be completely filled in by the treating physician / Hospital. Any missing information shall lead to delay in claims settlement.

Patient Name: Age Gender Male Female
Name of Hospital
Date of Admission Date of Discharge
Primary Diagnosis Secondary Diagnosis
Presenting Complaints With Duration of Illness

Any Associated Disease / Co-morbid With Duration

Details of Surgical, Gynecological or Obstetrical Procedure Performed (If Any)

Indication / Necessity of Performing Surgical Procedure/ LSCS
Type of Anesthesia Used : General Local Spinal Other:

I, hereby certify that my answers to the foregoing questions are correct and true, to the best of my knowledge and belief.

Signature & Stamp of the Attending Physician:
Name & Address:
Phone Number: Fax #
Credentials/Qualifications: Date:

EFU LIFE ASSURANCE LTD.

Health Office: 37-K, Block-6, PECHS, Karachi-75400.