EAST WEST LIFE
ASSURANCE COMPANY LIMITED
Formerly The Metropolitan Life Assurance Co. of Pakistan Ltd.

Karachi:
310, EFU House, M. A. Jinnah Road,
Karachi-74000. Ph: 2311662/5, 2310904, 2310726
Fax: 2311667

Lahore:
2nd Floor, Naqi Arcade, 71, Shahrah-e-Quaid-e-Azam,
Lahore. Ph: 042-6370717, 6362033, Fax: (042) 6370711

Rawalpindi:
55-A, Bank Road, Rawalpindi Cantt.
Ph: (051) 5514322, Fax: (051) 5520269

Website: www.eastwestlifeco.com E-mail: health.services@eastwestlifeco.com

NON-PANEL HOSPITALIZATION CLAIM FORM

- This form should only be used for non-panel hospitalization claims.
- Incomplete form is unacceptable and will be returned to the concerned employee.
- Please print clearly so that the information is easily readable.
- Please do not overwrite or use fluid on this form. This will render the form unacceptable and a new form will be required.
- Please attach all the following pertinent documents and original receipts along with this form:
  - Photocopy of "EWL Hospitalization Card"
  - Photocopy of employee's and patient's NIC.
  - All original bills with prescription & dates.
  - Discharge Card.
  - Doctor's Certificate specifying patient's illness.
  - Doctor's recommendation for hospitalization and/or laboratory test(s).

Section A: Information About Insured Employee

Employer's Name _____ EWL Hospitalization Card No. _____

Employee's Name _____ Designation _____

Patient's Name _____ Age _____ Patient is: Male ☐ Female ☐

Patient's full Address _____ Phone No. _____

Intimation Date _____ Authority Letter No. _____ Total Amount Claimed _____

Is this claim being paid from any other insurance policy? Yes ☐ No ☐ or any other source? Yes ☐ No ☐
If the answer is 'Yes' to any or both of the above questions, then please give details as below:

Name _____ Policy No. / Other Source _____ Receiveable Amount _____

Complete Address _____ Phone No. _____

I, the above named employee, do hereby declare that whatever has been stated above is true and correct to the best of my knowledge. I have not willfully concealed anything from the company. I hereby authorize East West Life Assurance Company Limited to obtain any information/reports pertaining to this claim regarding the illness of above mentioned patient from any Doctor and/or Hospital.

Employee's Signature _____ Date _____

Section B: Employer's Confirmation

We do hereby confirm that the above mentioned patient, whose claim is under process, is insured under our Group Hospitalization Policy with East West Life Assurance Company Limited. We authorize East West Life Assurance Company Limited to pay the claim up to the extent of the concerned patient's entitlements and according to the terms and conditions of the said policy.

Authorized Officer's Name _____ Designation _____

Signature _____ Date _____

Section C: Report From Doctor or Surgeon of Concerned Hospital

Name and Address of Referring Doctor _____

Hospital's Name and Address _____

Attending Doctor's or Surgeon's Name _____ Phone No. _____

Admission Date _____ Date of Discharge _____ Hospital Record No. _____

Admission due to: Emergency ☐ Non-Emergency ☐ Nature of Admission: Surgical ☐ Non-Surgical ☐ Maternity: Normal ☐ Caesarean ☐

Details of Diagnosis/Operation _____

Detail of Expenses During the Hospital Admission _____

Surgeon's Fee	Rs. _____	Anesthetist's Fees	Rs. _____
Room/Ward Rent	Rs. _____	Operation Theater/Labour Room Expenses	Rs. _____
Medicine Cost	Rs. _____	Consultant/Medical Officer Visit Fee	Rs. _____
Examination/Lab. Test Cost	Rs. _____	Miscellaneous Expenses	Rs. _____
Total Expenses	Rs. _____		

Doctor's Signature & Date _____ Hospital's Official Stamp _____

FOR OFFICE USE ONLY

Claim Receiving Date _____ Policy No. _____ Family Code _____

Patient's Code _____ Total Approved Amt. _____ Cheque No. _____

Date of Payment _____ Rejected Amt. (if any & Reason _____

Doctor's Opinion _____ Doctor's Signature _____

Authorized Officer's Opinion _____ Authorized Officer's Signature _____