CHARTIS EUROPE LIMITED
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HOSPITALISATION CLAIM FORM

NOTE: Please complete Section A of this form fully, and then pass the form to your medical practitioner for completion of Section B. This form must be supported by an In-Hospital Certificate which will be supplied on request by the hospital at which claimant was an in patient.

CHARTIS®

SECTION A

1. NAME OF POLICY HOLDER

2. POLICY NUMBER

3. ADDRESS

Daytime Phone No. ______________________

4. NAME OF CLAIMANT

Date of Birth: ____________________

5. NAME AND ADDRESS OF GENERAL PRACTITIONER

Phone Number: __________________

6. TIME SPENT IN HOSPITAL

Date admitted______________________

Date discharged______________________

7. NAME AND ADDRESS OF HOSPITAL

8. NAME AND ADDRESS OF DOCTOR GIVING TREATMENT IN HOSPITAL

9. REASON FOR HOSPITALISATION

Illness ☐ Injury ☐

10. PLEASE DESCRIBE ILLNESS OR INJURY

11. DATE OF FIRST CONSULTATION

Date _________________________

12. HAS THE CLAIMANT SUFFERED FROM THIS CONDITION BEFORE? IF YES, STATE, WHEN AND DURATION OF SYMPTOMS

13. IS THE CONDITION DUE TO PREGNANCY?

Yes ☐ No ☐

14. IF ACCIDENT, GIVE BRIEF SUMMARY, INCLUDING PRECISE TIME AND LOCATION

15. NAME AND ADDRESS OF ANY WITNESSES TO THE ACCIDENT IF APPLICABLE

16. ADDRESS OF INVESTIGATING POLICE/GARDA STATION IF APPLICABLE

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MEDICAL AUTHORISATION

On production of this Authorisation, or a photocopy thereof, I authorise you to furnish Chartis with full reports on the condition of ____ including the history of the complaint(s) which caused the above named to be admitted to Hospital on ____________________

SIGNATURE OF CLAIMANT ________________________________ D ATED ____________

NOTE *If the claimant is a child this authorisation should be signed by a parent.*

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SECTION B

To be completed by a qualified and registered medical practitioner, and supplied at the expense of the policyholder.

1. NAME OF PATIENT

Date of Birth_______________

2. IS ILLNESS OR INJURY ANYWAY RELATED TO PREGNANCY?

Yes ☐ No ☐

3. IF YES GIVE DETAILS

4. IF ILLNESS OR INJURY IS DUE TO ANY OTHER CAUSE, GIVE DETAILS

5. NATURE OF ILLNESS/INJURY

Diagnosis

Treatment prescribed

Any operation required

6. IN CASE OF ILLNESS, PLEASE STATE

When symptoms first appeared Date_______________

Date of first medical consultation Date_______________

Date condition was first diagnosed Date_______________

By whom illness was first diagnosed?

Date_______________

7. DATE ADMITTED TO HOSPITAL DATE DISCHARGED

Admitted ______________________ Discharged ____________

If the patient was referred to you, please state by whom

When was the patient first aware of this condition Date_________

Has the patient ever had the same or similar condition?

If yes please state when Date_________
Give Details

Did this contribute to hospitilisation? Yes ☐ No ☐
If yes, detail how it contributed to hospitalisation

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DECLARATION

I Certify that my answers to these questions are true and complete to the best of my knowledge and belief.

SIGNED ______________________________ DATED ____________

ADDRESS ____

______________________________ PHONE NUMBER ______________