GLICO LIFE INSURANCE CO. LTD, P.O.BOX 4251, ACCRA
TEL: 0302 246 140/0302 670 335

LOSS NO.: _____

HOSPITAL CASH CLAIM FORM

1. Name: _____ Policy No.: _____
2. Staff No.: _____ Contact Number: _____
3. Email address: _____
4. Employer's Name: _____
5. Employer's Address: _____
6. Occupation: _____ Age: _____
7. Height: _____ Weight: _____
8. Name of Hospital: _____
9. Name of Ward: _____ OPD/Folder No.: _____
10. Date illness started: _____ Place: _____
11. Nature of illness: _____

    _____
12. What is the name and address of the Doctor attending to you? _____
13. Is the above named Doctor your regular Doctor? _____

    If no to question 13, please state the name and address of your regular doctor: _____

    _____
14. How long have you been admitted as an inpatient in the hospital? _____

    From (date) _____ To (date) _____
15. Have you required medical or surgical treatment during the past five years?

    If yes, please give details: _____

    _____
16. Are you claiming under any other policy for this illness? _____

    If yes, please give details? _____

BANK DETAILS

a. Bank Name _____

b. Branch Name _____ Branch code : _____

c. Account Number: _____

DECLARATION

I declare that the above answers are true and correct to the best of my knowledge.

Signature: _____ Date: _____

CLAIMANT NOTICE:
STATEMENTS made shall be investigated. Any person who makes a claim based on any representation of the existence of a state of fact, knowing full well that the representation is false, stands the risk of having the claim repudiated as well as her/him being prosecuted for defrauding by false pretence contrary to section 131 of the Criminal Code Act 29.

MEDICAL CERTIFICATE

THIS CERTIFICATE IS TO BE COMPLETED BY A MEDICAL PRACTITIONER WHO ATTENDED TO THE CLAIMANT AS AN INPATIENT AT THE HOSPITAL OF ADMISSION.

1. Name of patient: _____
2. Reason for Admittance :_____
3. When did the patient first show symptom of disease? _____
4. (a) Is the patient suffering from any other disease or physical defect apart from the effects of those

   recorded in question 2 above? _____ If yes, please give details?_____

   _____

   (b) Is the admission caused by an acute or chronic illness? _____

   (c) Has the patient been seen by any other Doctor? _____

   If yes, state name of Doctor and address: _____
5. (a) How long was the patient admitted as an inpatient in your hospital? _____

   From (date) _____ To (date) _____

   (b) How long was the outpatient period before the admission for this illness? _____

   (c) How long will the admission last? From _____ To_____

DETAILS OF DOCTOR:

Name of Doctor: _____

Name and Address of Hospital: _____

Tel No.: _____ Code: _____

Fax:_____ Email: _____

Doctors Signature: _____ Date:_____

Hospital Stamp: _____

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