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MET INSURANCE

HOSPITAL CASH BACK BENEFIT CLAIM FORM

This form is issued without admission of liability. The form must be completed and returned together with an Invoice from the hospital. Proof of the patient's age must also be furnished if it has not previously been submitted to the company.

SECTION A – GENERAL QUESTIONS

Barclays Account Number ______________________ Barclays Account Owner ________________________________

Patient's full names ____ Date of Birth _______________ Age _________

Postal Address ____
____ _____________________

Home Telephone (_____) _______________Work Telephone (______) _________________Cell (____) ___________

Occupation ____Email address____________________________________

To which hospital were you admitted? ____

Name of your personal doctor/ physician______________________________ Telephone (_____) _______________

Name of the doctor who attended to you in hospital ____

If hospitalisation was due to an accident, please answer the following questions:

Date __________________ Place _________________________________ and Time _________________ of accident

How did the accident occur?
____

____

What injuries were suffered? ____

____

State period during which you were hospitalised due to the accident.

From: ____ To: ____

If hospitalisation was due to an illness, please answer the following questions:

Date ___________________ Place ____________________________________ and Time ______________ of illness

What was the illness? ____

What injuries were suffered? ____

State period during which you were hospitalised due to the illness.

From: ____ To: ____

SECTION B – DEATH OF THE PATIENT

Date of the death and cause of the death ____

Is there reason to believe that the deceased died as a result of suicide or as a violation of the law?
____

Was a post mortem done or is one to be held? ____

SECTION C – DECLARATION

The undersigned hereby declare that the above particulars are true in every respect and made without reservation. I further irrevocably authorize any doctor or any other person who has attended to me, or any hospital or other institution which has medical information about me, to disclose such information to Metropolitan Insurance and agree that this authority shall remain in force after my death.

Signed at _____________________________________ this __________________ day of ____________________ 20______

Barclays Account Owner __________________________________ Patient ____