AIG EUROPE S.A.
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International Financial Services Centre
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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.

SECTION A

1. NAME OF POLICY HOLDER

2. POLICY NUMBER

3. ADDRESS

Daytime Phone No. _____ E-mail _____

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 GARDA STATION IF APPLICABLE

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MEDICAL AUTHORISATION

On production of this Authorisation, or a photocopy thereof, I authorise you to furnish AIG 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 _____ DATED _____

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

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?

Yes ☐ No ☐

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 _____

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