AIG EUROPE LIMITED
30 North Wall Quay, International Financial Services Centre, Dublin 1.
Tel: +353 1 208 1400 Fax: +353 1 283 7773
E-Mail: postmaster.ie@aig.com

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

AIG Europe Limited is classified as a "Data Controller" under Irish Data Protection Legislation. By providing your Personal Information to AIG or Personal Information regarding other individuals you represent that you have the authority to do so and consent to the collection and processing (including the disclosure and international transfer) of this Personal Information as stated in the Privacy Policy which is available at www.aig.ie, by e-mailing postmaster.ie@aig.com or by writing to the Data Protection Officer at AIG Europe Limited, Ireland Branch, 30 North Wall Quay, International Services Centre, Dublin 1.

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 Give Details Date_____

Did this contribute to hospitilisation? Yes ☐ No ☐

If yes, detail how it contributed to hospitalisation

AIG Europe Limited is classified as a "Data Controller" under Irish Data Protection Legislation.By providing your Personal Information to AIG or Personal Information regarding other individuals you represent that you have the authority to do so and consent to the collection and processing (including the disclosure and international transfer) of this Personal Information as stated in the Privacy Policy which is available at www.aig.com, by e-mailing postmaster.ie@aig.com or by writing to the Data Protection Officer at AIG Europe Limited, Ireland Branch, 30 North Wall Quay, International Services Centre, Dublin 1.

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 _____

V1.2 122013