METROPOLITAN Cannon

HOSPITALIZATION CLAIM FORM – GROUP LIFE

Claimant's Details (To be filled by the Employee):

Scheme Name:____

Staff Member Name: ____

Staff Member Address:____

Staff Phone Number:____

Staff ID Number:____

Signature of Member: ____________________________ Date:_________________________

Hospitalization Details (To be filled by the Doctor):

Hospital Name:____

Date of Incident: ____

Date of Admission:____

Date of Discharge:____

Doctor's Name:____

Signature of Doctor: ____________________________ Date:_________________________

Hospital Stamp: ____

Payment's Details (To be filled by the Employer):

Payee Name:____

Bank Name: ____

Account Number: ____________________________ Branch:_________________________