MetLife

अमेरिकन लाइफ इन्स्योरेन्स कम्पनी

(संयुक्त राज्य अमेरिकामा संस्थापित, नेपाल दर्ता नं ६/०६२/०६३)

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IN-HOSPITAL / MEDICAL REIMBURSEMENT CLAIM FORM (अस्पताल भर्ना/औषधोपचार खर्च सोधभर्ना दावी फाराम)

A) INSURED'S SECTION (बीमितले भर्नुपर्ने)

1. Policy No. (बीमालेख नं.) ....

2. Name of Insured (बीमितको नाम) ....

3. Date of accident (दुर्घटनाभएको मिति).. वा or Date of sickness (बिरामी भएको मिति) ....

4. Nature of Disability : (असक्तताको प्रकृति) ....

5. Medical History of Disability (असक्तता सम्बन्धि चिकित्सकिय विवरण) ....

6. Have you ever had same or similar condition ? (के तपाईको कहिल्यै यस्तो वा यससँग मिल्दो जुल्दो अवस्था भएको थियो?) No-होइन) ☐ Yes -हो) ☐ Dates (मिति)..................................

AUTHORIZATION (अधिकार प्रदान)

“The undersigned hereby authorizes all physicians, hospitals, clinics, Pharmacists, Laboratories, Employers, Insurance Companies, other Companies, Institutions or any other persons who have any records or information about me to provide American Life Insurance Company any and all information with respect to my health and medical history, consultations, medical prescription, treatments or complete copy of my hospital medical record. A photographic copy of this authorization shall be as valid as the original”. I also authorize the company to deposit the payable claim amount in my below mentioned bank account.

मैले, म र मेरो स्वास्थ्य/उपचारसंग सम्बन्धित कुनैपनि जानकारी वा अभिलेख भएका सम्पूर्ण चिकित्सकहरु, अस्पतालहरु, औषधालयहरु, औषधि वितरकहरु, प्रयोगशालाहरु, रोजगारदाताहरु, बीमा कम्पनीहरु, अन्य संस्थाहरु वा अरु कुनै व्यक्तिलाई, अमेरिकन लाइफ इन्स्योरेन्स कम्पनीलाई उक्त जानकारी तथा अभिलेख उपलब्ध गराउन अधिकार प्रदान गर्दछु ।

भुक्तानीहुने दावी रकम मेरो तल उल्लेखित बैंक खातामा जम्मा गर्न अमेरिकन लाइफ इन्स्योरेन्स कम्पनीलाइ अधिकार प्रदान गर्दछु ।

Insured's Signature (बीमितको हस्ताक्षर) .... Date (मिति) ....Contact No. (सम्पर्क नं)............................E-mail (ईमेल)...........................

Bank Name (बैंकको नाम) ....Branch (शाखा)..Account No. (खाता नं.) ....

1.Please submit treatment related documents and original bills along with this form.

१.कृपया उपचारसंग सम्बन्धित कागजात तथा सक्कल बीलहरु यो फारमसगै पेश गर्नु होला ।

2.Please submit the physician's statement overleaf if you do not have detailed prescriptions and treatment related papers from the doctor/hospital.

२.पर्याप्त उपचारका कागजातहरु (प्रेस्क्रिप्सन, एक्स रे तथा ल्याब रिपोर्ट आदि) पेश हुन आएमा चिकित्सकको बयान फारम भर्न आवश्यक हुनेछैन ।

B) EMPLOYER'S STATEMENT (For AWI benefit only) (दुर्घटनाको कारण साप्ताहिक लाभको लागि मात्र)

1.Full name of Insured
बीमितको पूरा नाम...

2.Name and business address of Insured's employer
बीमितको रोजगारदाताको नाम र ठेगाना. ....

3.When was Insured compelled to give up his duties ? (Give exact date)
बीमित कहिले आफनो कार्य छोड्न बाध्य हुनुभयो (मिती खुलाउनुहोस्)? ....

4.When did Insured return to work ?
बीमित कहिले आफनो काममा फर्कनुभयो? ....

5.Was Insured's injury the sole cause of his absence from duty for all of the above period ? If not, give particulars.
के बीमित चोटपटकको कारणले गर्दा नै माथि उल्लेखित समयको लागि काममा उपस्थित हुन नसकेको हो? होइन भने विवरण खुलाउनुहोस् ।
....

आधिकारीक व्यक्तिको हस्ताक्षर (Authorized person's signature)...

नाम,थर (Name)..

पद (Title) ....

पुरा ठेगाना (Address)..................................

मिति (Date) ....

कार्यालयको छाप (Office seal)

C) PHYSICIAN / SURGEON SECTION

Name of Patient : .... Age.................... ☐ M ☐ F

1. Nature of Disability: ....
(Describe complications, if any)

If due to PREGNANCY, what was the approximate date of Inception? ....

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2. a) Nature and Medical History of Disability...

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b) Cause of disability: i) ☐ Due to Accident Date of Accident ....

ii) ☐ Due to Sickness Date of Sickness ....

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3. Has patient ever had same or similar condition? ☐ Yes ☐ No

If "Yes" state when and describe...

Name and address of referring Physician ....

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4. Describe fully nature of SURGICAL ....
(or Obstetrical) PROCEDURE

Date performed ....

Where performed ....

5. Dates of Treatment : OFFICE ....

Visit Charge...

Home ....

Visit Charge...

6. Is further operative procedure or treatment anicipated? ☐ Yes ☐ No

If "YES", explain ....

PHYSICIAN'S/SURGEON'S NAME: ....

SIGNATURE: ....

NMC No.: ....

Full Address: ....

Date : ....

Stamp