University of Sri Jayewardenepura
MEDICAL INSURANCE SCHEME
Surgical and Hospital Expenses Claim Form

EMP No: ……

Scheme	I		II		III		IV	
	A	B	A	B	A	B	A	B

No	Details	√
1	No of bills	
2	Diagnosis card	
3	Detail bill	
4	Payment receipt	
5	Doctor's seal/ Date	

EMPLOYEE'S

1. Name (in Full): ……..……...……...……..

……...

2. Designation (describe fully): ……...……

3. Whether Academic/Academic Support/ Administrative/ Non-Academic: ……..……..…….

4. Department/Division: …….…… Age: ……..…….....

5. Address: ……...…….

6. Telephone No: (Official): …… (Residence): ……. (Mobile): …….…….

DEPENDANT – (subject in respect of whom claim is made)

1. Name (in full)……..….. …….

2. Relationship ……..…….

INJURY – Please state

1. Date and place of Accident ……....…...…….

2. Precisely how the Accident Occurred ……..…….

3. Nature and Extent of Injuries …….

ILLNESS – Please state

1. Nature or Description of illness: ……...…….

2. Date of Commencement of illness: ……...…….

3. Date of first consultation regarding this illness: ……...…….

4. Name & the address of doctor who was first consulted ……..…….

PERIOD OF HOSPITALIZATION

From …… **To ……**

I HEREBY DECLARE that I have received the injuries above described and suffering from illness as above described, and I claim reimbursement under the above Medical Insurance Scheme in respect thereof. I hereby warrant that the above information are true and that I have not withheld from the University any material information connected with this claim.

[The application form should be submitted form with all the bills pasted on the separate paper and ensure that all the bills contain the dates and the seal or letter head of the Doctor. Duly completed application form should be put into the box after entering the register which keep at the Establishments (Information & Services) Division]

Details regarding bills (Medical/Hospital/Pharmacies)

(While the Doctor's Prescription should be annexed to bills obtained from pharmacies, all required documents to substantiate the information provided below should be submitted along with the application form.)

Bill No	Date of the Bill	Name / Names of patient/s who has received treatment	Relationship to Applicant	Purpose	Amount Rs.
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

I hereby state that I have claimed Rs…….. as Medical expenses as aforesaid and that the information provided in the claim form are true and accurate.

Date: ……. ……
Signature of Applicant

(For Office use only)

Academic Staff member of the Medical Faculty

The information given by the applicant and the document attached with respect to the diagnosis / recommendation by medical officer herewith have been checked and was found to be accurate.

Date: …… .....
Signature & Seal of the
Academic Staff member of the Medical Faculty

Recommendation of the Assistant Registrar/ Establishments (Information & Services)

After considering the receipts and other information provided by the applicant in relation to the medical treatment received. I recommend the reimbursement of total expenses / an amount of Rs. …….of total expenses incurred by him/her in the connection.

Date : …… ……...
Signature of the Assistant Registrar
Establishments (Information & Services)