CENTRAL OFFICES:
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LIBERTY LIFE

DOCUMENT FOR OUT OF HOSPITAL TREATMENT - MEDICAL EXPENSES ANALYSIS

Name of Insured: ..... Policy No: .....
Name of Patient: ..... Date of Birth: ..... Agent: .....

PART I. TO BE COMPLETED BY THE ATTENDANT DOCTOR | Doctor's Fee

The undersigned doctor speciality ..... examined to-day Mr/Miss/Mrs ..... and I diagnosed ..... | €

Amount received | €

Name of Doctor ..... Telephone ..... Signature ..... Date .....

PART II. PRESCRIPTION FOR MEDICINES – To be completed by the attendant doctor

1. ..... 2. ..... 3. .....
4. ..... 5. ..... 6. .....

Name / Seal of Pharmacy ..... Telephone ..... Signature ..... Date .....

PART III. LABORATORY TESTS – To be completed by the attendant doctor

1. ..... 2. ..... 3. ..... 4. ..... 5. .....
6. ..... 7. ..... 8. ..... 9. ..... 10. .....

Name of Laboratory ..... Telephone ..... Signature ..... Date .....

PART IV. X-RAYS – To be completed by the attendant doctor

1. ..... 2. ..... 3. ..... 4. ..... 5. .....

Name of Radiologist ..... Telephone ..... Signature ..... Date .....

INSURED'S CLAIM DECLARATION

PART A. TO BE COMPLETED BY THE INSURED AND POLICY OWNER

Name of Insured: ..... Policy No: .....
Patient: ..... Date of birth: ..... Relationship ..... Date of Cover: .....
AILMENT: Diagnosis .....
(If the ailment is due to injury from accident, where and how if happened) .....

Symptons first appeared of ailment - Date .....
Have you ever suffered previously from this ailment; if yes, explain; .....
Name of Doctor consulted ..... Date of consultation: .....

I hereby certify that the above answers are true and correct and I authorize all Doctors or other persons who treated me, and all hospitals or other Institutions to furnish full information regarding this claim to LIBERTY LIFE INSURANCE PUBLIC COMPANY LTD

Date ..... Signature of Insured .....

Date ..... Signature of Policy Owner .....

PART B. TO BE COMPLETED BY THE ATTENDANT DOCTOR IN CASE OF IN PATIENT

Name of Insured: ..... Age: .....

1. Sickness of Bodily Injury: .....

.....

2. If due to pregnancy, when did pregnancy start; Date: .....
3. When did symptoms first appear or accident happen; Date: .....
4. When did patient visit you for above condition; Date: .....
5. Nature of surgical or obstetrical procedure, if any: .....

.....

.....

Date ..... Doctor's Signature .....

PART C. TO BE COMPLETED BY CLINIC

Name of Clinic: ..... Date of Admission: .....

Address: ..... Date of Discharge: .....

BILL ANALYSIS

Room & Board ..... Days X ..... daily	€ .....
Operating Room	.....
Anasthetic fees	.....
Laboratory tests	.....
X-Rays	.....
Drugs (Give quantities and kind of medicines)	.....
Electrocardiogram	.....
	Total € .....

I hereby certify that according to the regards of the Clinic, the above services have been rendered to the above patient.

Date ..... Signature of Authorized Clinic Representative .....