University of Colombo

(FOR OFFICE USE ONLY)

Medical Welfare Scheme - 2024

Surgical and Hospital Expenses Claim Form

EMP No. : …… **Scheme I** ☐ **Scheme II** ☐ **Scheme III** ☐

EMPLOYEE'S

1. Name (in full) :……..
2. Designation (describe fully) ……..……...…….……
3. Whether Academic/Academic Support/Administrative/Non-Academic: ……
4. Department: :…… Age: ……..
5. Address : ……..…….
6. Telephone No: (Official): ….…… (Residence):……(Mobile): ……..……

(Please submit the form with all the bills pasted on the separate paper by entering the relevant register at the Student and Staff Affairs Branch. Also ensure that all the bills contain the dates and the seal of the Doctor.)

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 ……..…..……

GENERAL INFORMATION

1. Have you ever had the same illness before? If so, give particulars and date	
2. Have you during the past five years had any illness or accident necessitating Medical attention? If so, give full particulars	
3. Have you previously suffered from sickness accident injury, which has given rise to a claim to any Insurance Company or upon any Benefit/ Society or Fund? if so give full particulars	
4. Are any claims pending or are you entitled to claim upon any other insurer, Society or fund in respect of any illness or any injury suffered by you?	
5. If you are undergoing treatment for the injury or illness to which this claim relates, please state? a) Nature of illness b) Nature of treatment	

c) Name of hospital concerned if any d) Name of any Consulting Specialists Whose recommended treatment you or have been receiving giving details of the treatment concerned and other Specialist services received.	

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 Welfare Scheme in respect thereof. I hereby warrant that the above statements and facts are true and that I have not withheld from the University any material information connected with this claim.

Witness …… (Signature) ……
Date ……. Date ……..

Total amount of all receipts (bills) : Rs:…….

TO BE COMPLETED BY THE PATIENT'S GENERAL PRACTITIONER/ SURGEON

a) Name of patient (in full) ……..…….
b) Condition that necessitated investigation or treatment ……..…….....
c) General practitioner by whom referred ……..……..
d) Diagnosis of disease ……..……
e) Details of treatment or operation and prognosis ……..……...…….....
f) Was the onset of illness acute, sub acute or chronic? ……..……....
g) For how long would the patient have suffered from these symptoms and signs?.....
h) Period of hospitalization ……..…..…….…
Date of admission…… Date of discharge ……..…..……
i) State approximately when, in your opinion the ailment could have BEGUN or been CONTRACTED by the patient ……..……..…...

I certify that I am the General Practitioner/ Surgeon of the patient of the referred to above, and that I approved the services for which this claim is made.

Date: …….. ……..
Signature of the Practitioner/ Surgeon/ Specialist
who attended on this patient for this ailment

Name of Practitioner/ Surgeon:**……..……**
Qualifications:**……..……...…**
Address:**……..……..**
T.Phone No.:**……..……...**
(To be completed by surgeon all cases as surgical and surgical treatment)

----------***(For Office use only***----------

Recommendation of the Head of the Department

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

Date: …….. ……..……..……..
Signature of the Head of the Department (Seal)

The information given by the applicant and the document attached herewith have been checked and recommended/ not recommended reimbursement of the total expenses.

Date: …… ……..……
Academic Staff member of the Medical Faculty (Seal)