



# Hospital Cash Benefit

**LIFE INSURED**

**POLICY NUMBER**

**EMAIL ADDRESS**

1. Please state the exact nature of the illness/disease/injury for which you are/were hospitalised.

Please confirm the date that you first attended a doctor for this condition.

2. What were your symptoms?

What date did they first start?

3. Please give details of all surgery/treatment/procedures undertaken.

4. Have you previously suffered from this or any related condition? Yes      No

If yes, please give details.

**Continued overleaf**





# Certificate of Hospitalisation

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**LIFE INSURED**

**POLICY NUMBER**

**EMAIL ADDRESS**

1. Please state the exact diagnosis of the condition for which the patient attended hospital.

2. Was there any underlying illness? If so, please give details including any previous history.

3. Please detail all surgery/treatment/procedures undertaken.

4. What was the date of the first consultation for this condition?

5. Please advise the name and address of the referring doctor.

Name:

Address:

6. Was the stay in hospital for the purpose of cosmetic or elective surgery?

Yes

No

If yes, please give details

7. Please specify the exact time and date of admission and discharge.

**Admission:** Time : Date

**Discharge:** Time : Date



Please sign and date.

Signature:

X

Date:

Hospital stamp:

**Zurich Life Assurance plc**  
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