CLAIM FORM

Medical, Surgical And Personal Accident Insurance Cover

MAURITIUS UNION GENERAL INSURANCE

Editable PDF

*** Fields highlighted in Red are Mandatory**

SECTION A

Insured's Name : LYCÉE LABOURDONNAIS

Insured's Address :

RUE ROCHECOUSTE, FOREST SIDE, CUREPIPE

Phone No. : 6706097 Mobile No. : Policy No. : 3371/13/R

Beneficiary's Name :

Beneficiary's Address :

Profession : Student Beneficiary's Age :

SECTION B

ILLNESS Yes ☐ No ☐

Nature of illness :

Symptoms experienced :

Date when first experienced :

Did you suffer from illness previously? Yes ☐ No ☐

(If Yes, please give details:)

Did you first undergo a check up relating to this illness? *(If Yes, please give details:)* Yes ☐ No ☐

Doctor's Name :

Doctor's Address :

Phone No. : Date :

4, Léoville l'Homme Street
Port Louis, Mauritius
www.mauritiusunion.com

Tel 230 207 5500
DL 230 203 2540
Fax 230 207 4188
Brn C07000714

SECTION B

ILLNESS

What was the diagnosis?

.....

What treatment was prescribed?

.....

Were you hospitalised? Yes ☐ No ☐

Note: If an operation was undergone further to the above illness, please fill in SECTION D also

SECTION C

ACCIDENT

Yes ☐ No ☐

Date of Accident : ..... Place of Accident : .....

Circumstances of Accident :

.....

Nature of injuries sustained : .....

Name and address of treating doctor :

.....

What treatment was prescribed?

.....

Are there any chances of permanent incapacity?

.....

SECTION D

OPERATION UNDERGONE (Note : Section B & C must be completed before completing this section)

Yes ☐ No ☐

Surgical intervention recommended by Doctor

Name : .....

Address : .....

Phone No. : ..... Date : .....

Operation was carried out at : .....

Operation was carried out by Doctor : .....

Phone No. : ..... Address : .....

SECTION E

GENERAL (must be completed in any cases)

Please give the amount of medical expenses incurred : Rs .....

Is the treatment relating to this illness / accident now completed? Yes ☐ No ☐

If not, will there be any further expenses? Yes ☐ No ☐

.....

Do you have any other medical / surgical / personal accident insurance cover? Yes ☐ No ☐

(If Yes, please give details:)

.....

(N.B: Kindly attach all original documents, e.g. Invoices, medical report, etc. substaining the claim)

I, the undersigned Mr / Mrs .....

hereby declare that all the information given above is true to my knowledge, and that I have neither retained nor concealed any information regarding the claim put forward. I am fully aware that all false declaration and/or non-disclosure of material facts shall render this claim null and void and will entail the termination of the contract.

I authorise Mauritius Union Assurance Co. Ltd to contact my treating doctor in respect of any complementary information required in relation to my illness or treatment received in relation to the claim and as regards my medical history and also authorise that these information be communicated to Mauritius Union Assurance Co. Ltd.

Date : .....

Insured's Signature: .....

Beneficiary's Signature: .....

** Insured's Signature Field not visible? Click 'Check my Form' ** >> Check my Form <<