



**CELL INSURANCE**  
COMPANY (PVT) LTD

**THE WALLET DOCTOR**  
**Hospital Cash Plan Claim Form**

Please answer all questions in all sections

Full Name of Insured

Policy Number

Patient/Dependant Hospitalised

Contact Address

Indicate reason for Hospitalisation  Illness  Accident

Date admitted  Time of admission

Name of admitting Doctor

AHFoZ Number  Time discharged

Date discharged

Name of discharging Doctor

AHFoZ Number

Name of Hospital

AHFoZ Number

Name of Medical Funder, if any

Bank details of the Insured

Preferred method of payment Bank  Mobile

Date  Signature

NB: Please attach confirmation of hospitalisation from your Doctor or Hospital and a copy of your National Identity Card

***Insurance fraud is a crime***

