EAST WEST LIFE
ASSURANCE COMPANY LIMITED
Formerly The Metropolitan Life Assurance Co. of Pakistan Ltd.

Karachi :
310-Qamar House M.A. Jinnah Road, Karachi-74000.
Tel : 2311662/5, 2310726, 2310904 Fax: 2311667

Lahore :
2nd Floor, Naqi Arcade 71, Shahrah-e-Quaid-e-Azam, Lahore.
Tel : (042) 6362033, 6370717 Fax : (042) 6370711

Rawalpindi :
55-A Bank Road, Rawalpindi Cantt.
Tel : (051) 5514322 Fax: (051) 5520269

UAN: 111-EWL-111 (111-395-111) Website: www.eastwestlifeco.com E-mail: client.services@eastwestlifeco.com

HOSPITALIZATION INTIMATION FORM

- In case of non-emergency hospitalization, this form must be received by this company 5 days prior to schedule admission date.
- In case of critical illness related hospitalization, this form must be received by the company at last 10 days prior to schedule admission date.
- In case of emergency hospitalization, this form must be sent to the company within 24 hours after the patient is admitted into the hospital.
- This form can also be faxed to the above provided number.
- Please note illegible, incorrect and/or incomplete information will delay approval.
- Please write in block letters.

Section A : Hospital Information

Name of Hospital _____

Hospital's Address _____

Name of Contact Person _____ Designation _____

Telephone _____ Fax _____ E-Mail (If any) _____

Section B : Patient's Information

Employee's Name _____ EWL Hospitalization Card No. _____

Patient's Name _____ Patient's NIC No. _____

Section C : Admission Information

Please complete this section wheather your admission, is on a Emergency or Non-Emergency basis.

Name of Referring Doctor _____ Name of Attending Doctor _____

Date of Admission _____ Time _____ Bed/Ward/Room No. _____ Hospital Record no. _____

Reason for Hospitalization _____

Place (If Accident) _____ Nature of Injury (If accident) _____

Brief History and Examination _____

Provisional Diagnosis _____

Surgical procedure planned (If any) _____

Expected Date of Surgery _____ Estimated Length of Stay _____ Estimated Cost _____

Attending Doctor's Signature _____ Attending Doctor's Phone No. _____

Section D : Declaration

I hereby declare that whatever stated above is true and correct to the best of my knowledge and I have not with held any
information. I hereby authorise East West Life Assurance Company Limited to investigate/verify the information provided in this form in any manner before according approval for this particular hospitalization.

Date _____

_____
Signature of employee for self and on behalf of the patient

FOR OFFICE USE ONLY

Policy No. _____ Family Code _____ Patient Code _____ No. of day approved _____

Attended by _____ Authorized Amount _____

Authority letter No. _____ Authority letter Date _____

Illness: Normal ☐ or Critical ☐ Maternity: Normal ☐ or Caesarian ☐

Doctor's Remarks _____

_____

Doctor's Signature _____ Date _____