

Traveller's Insurance - Hospital Report דו"ח בית החולים

To the Hospital's admitting office,

As per Policy conditions you are entitled to collect from insured a US\$ 50.- "Deductible" for each medical event.

Policy No. _____

CLAL INSURANCE
Clal Insurance Pensions & Finance Group
48, MENACHEM BEGIN RD., TEL-AVIV 66184
TEL: 03-6387486
FAX: 03-6397006, 03-6387475
כלל עולמי

Please, notify "MedLine Israel Ltd." immediately of this case.
All accounts together with your MEDICAL REPORT should be sent to them. "MedLine Israel Ltd." shall reimburse you according to terms, conditions & exclusions of this policy (See front inside cover).

Thanking you for your cooperation, **Clal**

1. Surname _____ First Name _____ Age _____ Date of Admittance _____
 2. Cause of hospitalization: Accident. Acute illness. (Chronic, pre-existing, elective, cosmetic & mental illnesses are NOT COVERED under this policy).
 3. Diagnosis _____
 4. Short case History _____

 5. Nature of Complaints _____
 6. Has Patient been Discharged? _____ (Yes/No). Date _____ Diagnosis upon Discharge _____
 7. Remarks _____
 8. Name of Hospital _____ Name of attending Physician _____
- Signature and Stamp X _____ Date _____ Place _____