



#### 4. Hospital Care Cover

Please provide either a proof of hospital stay and complete the details of the stay in this section or arrange for a member of staff at the hospital to fully complete this section.

Patient Surname																								
Patient Forename									Date of Birth	D D		/	M M		/	Y Y								
Patient Address																								
Reason for hospital admission																								

Please tick as appropriate

In-patient  Day-patient  Out-patient surgery  Proof of hospital stay attached

Admission date(s)  /  /   /  /

Discharge date(s)  /  /   /  /

Please provide the dates for any periods of leave during the stay:

/  /  to  /  /

/  /  to  /  /

/  /  to  /  /

Hospital stamp

If the patient was over three months old, under 11 years and was accompanied by a parent please provide the following:

Parents Surname																								
Parents Forename																								

I certify that the above details are true and correct.

Name																								
Position																								

Hospital representatives signature

Date

#### 5. Birth of a child

Please provide a certified copy of the birth certificate or adoption papers.

Child 1	Surname																								
	Forename									Date of Birth	D D		/	M M		/	Y Y								
Child 2	Surname																								
	Forename									Date of Birth	D D		/	M M		/	Y Y								
Child 3	Surname																								
	Forename									Date of Birth	D D		/	M M		/	Y Y								

Please tick if the multiple births were a result of in-vitro fertilisation or assisted conception

#### 6. Declaration and signature

I hereby declare that the information given by me in relation to this claim is complete and accurate and I give my permission for AXA PPP healthcare to make any reasonable enquiries that it deems necessary to validate this claim.

Policyholder's signature

Date