STATE LIFE

INSURANCE CORPORATION OF PAKISTAN

FORM NO: [H104]
PANEL HOSPITAL DETAILS

HOSPITAL DETAILS FORM FOR CORPORATE HEALTH INSURANCE

Hospital Details:

Hospital Name: Health Commission Registration No.	**Hospital Category:** ☐ Hospital ☐ Nursing ☐ Day Care Center ☐ Single Specialty ☐ Children's Hospital

Ownership: ☐ Individual ☐ Partnership ☐ Pvt. Ltd ☐ Trust ☐ Armed Forces

Total No. of Operational Beds: _____

ER Beds	☐	Ward Beds	☐	Burns Beds	☐	CCU/HDU	☐
Private	☐	Semi-Private	☐	Isolation Beds	☐	VIP	☐
ICU	☐	Neonatal ICU	☐	Ventilator Beds	☐	EXECUTIVE	☐

SLIC Assessment officer: _____

Visiting Officer Designation: _____

Date of Visit: _____ Signature: _____

Complete Address:		Email:
City/Tehsil:	District:	**GPS Coordinate:** Latitude: Longitude:

Details of Focal Person:

First Shift	Second Shift	Third Shift
Name:	Name:	Name:
Cell Number:	Cell Number:	Cell Number:
Landline:	Landline:	Landline:
Email:	Email:	Email:
Timings:	Timings:	Timings:

Reception Contact Number:	**Corporate office number:**
Email:	**WhatsApp Number (If any):**

Bank Account Details:

Account Title:	Bank Name:
IBAN: ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐	

Tax Details:

NTN/FTN:	NTN Category:	NTN Status:
CNIC:	Applicable WHT/GST Rate:	Exemption: ☐ Yes ☐ No

Required Documents:

Please attach following documents with the form:

- ☐ Hospital Registration Certificate
- ☐ Details of Management
- ☐ Hospital Profile
- ☐ List of Doctors
- ☐ List of Facilities
- ☐ Standard Rate List with offered discount (Excel & PDF)