## INTIMATION FORM FOR LIMIT ENHANCEMENT

| | |
|---|---|
| **FROM (HOSPITAL NAME):**<br><br>**PATIENT NAME:**<br><br>**EMPLOYEE ID:**<br><br>**POLICY HOLDER:** | **To :**<br>**ALFALAH INSURANCE HEALTH DEPARTMENT**<br><br>**DATE:** |

| | |
|---|---|
| **Reason for limit enhancement** | |
| **Already given treatment** | |
| **Important findings in the reports/ investigations** | |
| **Further treatment/Plan?** | |

| |
|---|
| **INSTRUCTIONS FROM ALFALAH INSURANCE COMPANY LTD** |