Policy Number: 17777C

Personal ID Number:_________________

RWTO/OERO Manulife Comfort Care Remuneration

Name:____

Hospital: Name:______________________________

Address:____________________________

Dates: Admission:_________________________________

Discharge:_________________________________

Number of Days claimed: _________

Total:_______X $25.00 = _______________

(Day of discharge is not included.)

Attending Physician or Family Doctor:

Name________________________

Address:______________________

Phone number:___________________