Policy Number: 17777C

Personal ID Number _______________

RWTO/OERO Convalescent Care Remuneration after Hospital Stay

Name:____

Hospital: Name:_______________________________

Address:_____________________________

Dates: Admission:__________________________________

Discharge:__________________________________

Date when you think daily activities will be resumed:__________________

Number of months claimed: ___________X$350.00 = ________________

(Maximum number is 6)

Attending Physician or Family Doctor:

Name_________________________

Address:______________________

Phone number:___________________