MEDICAL POLICY

CLAIM FORM

DIRECTIONS:
Please read carefully and fill out the entire form.

1. This form must be completely and legibly filled out in BLOCK letters in order for us to process your claim.
2. Complete a separate claim form for each insured individual and for each visit to the doctor or service provider.
3. Attach ALL medical bill(s) relating to the claim.
   a) Make certain all bills identify the patient.
   b) All bills should indicate date of treatment, description of service and charges.
4. Date and sign the form and ensure that the same is signed and stamped by the Doctor/Provider in the space provided.
5. Incomplete claim forms will delay processing of the claim.
6. No claim will be considered if submitted after 90 days from the date of illness.

EMPLOYEE (MEMBER) INFORMATION *(This is the individual whose name is on the ID card)*

Scheme ____________________

Name ____________________

ID No. ____________________ Member No. ____________________

Postal Address ____________________ Postal Code ____________________

Telephone - Office ____________________ House ____________________ Mobile ____________________

Fax ____________________ Email ____________________

PATIENT INFORMATION

Patient Name ____________________

Membership Number ____________________ Sex: Male ☐ Female ☐

Date of Birth *day/month/year* Relationship: Employee ☐ Spouse ☐ Child ☐

AUTHORISATION FOR RELEASE OF INFORMATION *(Patient or parent must sign below)*

I hereby warrant the truth of the above statements, that I have not withheld from The Jubilee Insurance Company of Kenya Limited any information relating to this claim. I have no objection to The Jubilee Insurance Company of Kenya Limited and/or their representatives communicating with the Doctor/Physician or Hospital I have consulted or visited and shall submit to any medical examination(s) if so required by The Jubilee Insurance Company of Kenya Limited.

Signature of patient or parent (if patient is a minor) ____________________ Date ____________________

MEDICAL INFORMATION *(To be completed by the Doctor/Physician treating the patient)*

What was the nature of illness or injury from which the patient suffered?

Is this condition recurrent or chronic?

Date(s) of previous treatment for this illness or injury 1. *day/month/year* 2. *day/month/year* 3. *day/month/year*

Any underlying conditions which could result in this illness or injury?

Nature of treatment

Was the patient referred to a specialist? Yes ☐ No ☐

If yes, provide details of the specialist

In case of accidental injury, provide details

CERTIFICATION BY MEDICAL PRACTITIONER

I certify that the above information regarding Mr/Mrs/Mst/Ms. ______________________________

______________________________ is true, to the best of my knowledge and the expenses incurred ARE as a result of the accident/illness referred to.

Name and address of Doctor/Physician ______________________________

Qualifications ______________________________

Date ______________________ Signature and Official Stamp ______________________