

MEDICAL POLICY



CLAIM FORM

The Jubilee Insurance Company of Kenya Limited Head Office:

Jubilee Insurance House, Wabera Street,
P.O. Box 30376 - 00100 GPO, Nairobi, Kenya
Email: jic@jubileekenya.com

Mombasa:

Jubilee Insurance Building, Moi Avenue,
P.O. Box 90220 - 80100, Mombasa, Kenya
Email: mombasa@jubileekenya.com

Kisumu:

Jubilee Insurance House, Oginga Odinga Road,
P.O. Box 378 - 40100, Kisumu, Kenya
Email: kisumu@jubileekenya.com

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.
7. Providers are advised to cross check the medical card against the national ID card for adult patients to ensure that member details are correct.

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

Scheme	<input type="text"/>		
Name	<input type="text"/>		
ID No.	<input type="text"/>	Member No.	<input type="text"/>
Postal Address	<input type="text"/>	Postal Code	<input type="text"/>
Telephone - Office	<input type="text"/>	House	<input type="text"/>
		Mobile	<input type="text"/>
Fax	<input type="text"/>	Email	<input type="text"/>

PATIENT INFORMATION

Patient Name	<input type="text"/>		
Membership Number	<input type="text"/>	Sex:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of Birth	<input type="text" value="day/month/year"/>	Relationship:	Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>

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 is the diagnosis for the patient?

Is this condition recurrent or chronic?

Is this condition congenital?

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 _____