MEDICAL POLICY

CLAIM FORM

Jubilee INSURANCE

The Jubilee Insurance Company of Kenya Limited
Head Office:
Jubilee Insurance House, Wabera Street,
P.O. Box 30376 - 00100 GPO, Nairobi, Kenya
Tel: +254 20 3281000
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 forms shall not be processed.*
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.*
8. *All invoices must be signed by the client.*

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 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 _____