New Jubilee Insurance Company Limited

Head Office: 2nd Floor, Jubilee Insurance House, I.I Chundrigar Road, P.O. Box 4795, Karachi 74000
UAN:111-654-111 Call Centre: Ext. 322 & 523 Tel: 021-2416022-26 Fax: 021-2425774
Email: nji@nji.com.pk Website: www.nji.com.pk

Inpatient Claim Form

Section – 1 Policyholder Detail

Name of Policyholder: ______________________________

Father's Name: ______________________________

Policy No. ______________________________ Policy Commencement Date: ______________

Residential Address: ______________________________

Business Address: ______________________________

Phone Nos. Residence: ______________ Cell: ______________ Business: ______________

I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient. I hereby authorize any Hospital, Physician, Insurance Company or any other organization that has any kind of record or knowledge of my or my family's insured members' medical history to furnish it to New Jubilee Insurance Company Limited. A copy of this authorization shall be deemed as effective as the original.

____
Policyholder's Signature
(same as in the application)

Date: ______________

Section – 2 Claimant / Patient Detail

Name of Patient: ______________________________ Age: ______________

Father's / Husband's Name: ______________________________

Address: ______________________________

Date of Injury or beginning of sickness: ______________________________

When was Physician first consulted? ______________________________

Nature of Injury or Sickness: ______________________________

When patient did first noticed changes in his / her present health condition? ______________________________

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Date of Admission: ______________________________ Date of Discharge: ______________

Name of Hospital and Address: ______________________________

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Name of Physician / Surgeon: ______________________________

Has the patient suffered similar condition before? Yes ☐ No ☐

Provide details of treatment and Doctor's name: ______________________________

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Note: Please submit following documents with claim form

*Supporting documents
• Discharge card/clinical summary • Prescriptions
• Itemized hospital bill • Diagnostic Reports • Payments Receipts

Incomplete or missing documents will cause delays in processing the claim.

Section – 3 (To be Completed by Attending Physician / Surgeon)

Name of Patient: ______________________________ Age: ______________

Father's / Husband's Name: ______________________________

Name / Address of referring Physician if any? ______________________________

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Name of Hospital and Address: ______________________________

____

Name of Physician / Surgeon: ______________________________

Date of Admission: ______________ Date of Discharge: ______________

Source of Admission: ☐ Emergency ☐ Elective / Planned ☐ Other

Patient Registered as: ☐ Bed Patient ☐ Outpatient

When did you attend patient first for this condition? ______________________________

Are you a relative of the Policy holder / Patient? If yes, please mention relationship: ______________

Date of Operation if applicable: ______________ Type of Anesthesia: ______________

Primary Diagnosis: ______________________________

Final Diagnosis: ______________________________

Treatment Given during hospitalization: ______________________________

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Name of Signing Doctor : ______________ PMDC Reg. No: ______________

Signature: ______________ Date: ______________

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