



NEW JUBILEE INSURANCE COMPANY LIMITED

Jubilee Insurance House, I.I. Chundrigar Road, Karachi - Pakistan
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TRAVEL ACCIDENT & HOSPITALISATION INSURANCE CLAIM FORM.

THIS FORM MUST BE RETURNED TO THE COMPANY IMMEDIATELY WITH ALL QUESTIONS FULLY ANSWERED.
(The company does not admit liability by the issue of this form).

Name: _____ Sex: _____

Age : _____ Policy No. : _____

Address: _____

In case of death claim, state date of death _____
(Death certificate must be attached)

In case of Medical Reimbursement claim
State amount of Hospital Bill in Rupees _____
(Copy of the Bill must be attached)

Date of Accident _____ Time of Accident _____ Place of Accident _____

Describe the accident in detail _____

Hospitalization / Reason for Hospitalization _____

Are you making any other insurance or compensation claim as a result of this accident?
Yes / No Name of the Company _____

Were you traveling? If so: From _____ To _____

Exact conveyance (state name of train, bus Number / route, airline flight number etc.) _____

Describe injury / disease _____

Name of attending Doctor : _____

Doctor's Address: _____

If hospitalized, give name and address of Hospital _____

Confined to Hospital: From _____ To _____

I, the above claimant, being duly sworn, depose and say that the foregoing statements are full and true to the best of my knowledge and belief, and agree that payment according to the terms of the policy, shall be a full satisfaction and discharge of any and all claims, the cause of which originated prior to date hereof.

Signed _____

Date : _____

AUTHORIZATION

I hereby authorize any hospital., physician, or other person who has attended or examined me, to furnish to the insurance company, or its authorized representative, any and all information with respect to any injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photo static copy of this Authorization shall be considered as effective and valid as the original.

Signature of the Claimant _____

ATTENDING PHYSICIAN'S STATEMENT ACCIDENT / ILLNESS

In evidence of the claim of :

Name: _____

Date if Accident / Approximate onset of Disease _____

Nature of injury / disease _____

If fracture or dislocation,
state whether complete or
incomplete

If fracture of long
bones, state whether
racture is through
shaft or extremity.

Was it
confirmed
by X-ray

Complete / Incomplete

Shaft / Extremity

Yes / No

If Surgery, describe in detail _____

When did patient first consult you for this condition? _____

Date: _____

What post history of any ailment was disclosed by the patient?

If any please give details _____

Describe any other disease or infirmity affection present condition _____

Give date of treatment and type of treatment rendered : Office / Home / Hospital

Is patient still under your care for this condition ? Yes / No

If discharged, give date : _____

If patient hospitalized, give name and address of the hospital: _____

Date of admitted _____ Date of discharged _____

I hereby certify that my answers to the foregoing questions are correct and true, to the best of my knowledge and belief, without evasion or reservation.

Signed : _____

Attending Physician

Address: _____

Date: _____