



INPATIENT CLAIM FORM FOR GROUP MEDICAL INSURANCE

Before Filling This Form READ THE INSTRUCTION Overleaf

SECTION I

Insured's Information

Most of the information required below is available from your "Authorization for Hospitalization"

Policyholder/Employer:- _____ Amount Claimed:- _____

	Authority letter No.	Name	Birth Date	Occupation /Relationship
Employee	_____	_____	_____	_____
Patient	_____	_____	_____	_____

Patient's Address: _____

Is any part of this claim recoverable:
 (i) under another insurance policy Yes _____ No _____ (ii) from any other third party Yes _____ No _____

If "Yes" please give details below:
 Name _____ Policy No. _____

Address: _____

I, the above named employee, declare that the information given in this form is, to the best of my knowledge, Correct. I authorise New Jubilee Insurance Co. Ltd. (The Company) to obtain any Hospital or Doctor's report Concerning the illness for which this claim is made. I attach original bills for reimbursement according to the policy

Signature _____

Date: ____/____/____

SECTION II

Employer's Verification

We confirm that the patient in respect of whom benefits are claimed is an eligible insured, covered under our Group Medical Insurance Policy, referenced in Section I above.

We authorise New Jubilee Insurance Company Limited (The Company) to settle this claim in accordance with the patient's available benefit entitlement under the terms of the Group Medical Insurance Policy referenced in Section I above. Upon written notification from the Company, we will arrange to recover from our employee any amount paid on the patient's behalf by the Company that are in excess of the patient's benefit entitlement.

Signature of Authorised Official: _____ Date: ____/____/____

Name _____ Designation _____

SECTION III

Attending Physician's or Surgeon's Report

Name & Address of Referring General Practitioner _____

Hospital's Name & Address: _____

Name of Attending Physician or Surgeon _____

Along with qualification & Tel #: _____

State whether the patient was treated as a registered bed-patient or as out-patient _____

State if hospitalization was due to an emergency or for a check-up: _____

DATE OF HOSPITALIZATION: From: ____/____/____ To: ____/____/____

From	To	Details of Investigations, Operation, Treatment

DIAGNOSIS _____

Signature: _____ Date: ____/____/____ PMDC Registration No. _____

INSTRUCTIONS

Please Follow These Instruction Carefully (For Reimbursement)

EMPLOYEE

1. This form must be completed by all employees, even if the Patient has been admitted to an NJI authorised hospital.
2. Fill in a separate form for each patient.
3. Complete and sign Section I yourself.
4. Have your Employer verify Section II
5. Have your hospital Doctor complete Section III.
6. Send the completed claim form, together with the original Prescriptions and receipt, to:

The Senior Vice President
Accident & Health Department
New Jubilee Insurance House
I.I. Chundrigar Road,
P.O. Box 4795
KARACHI - 2

EMPLOYEEER

1. Please check the information filled in by your Employee in Section I.
2. If the information in Section I is satisfactory, please complete The verification in Section II.

DOCTOR

1. Please complete Section III.
2. Please state the dates of hospitalisation, and the dates of treatment.
3. Under the details please give a brief summary of your tests and findings.
4. Write down your diagnosis.
5. Sign and date Section III.