HEALTH CARE TAKAFUL
Inpatient Medical Claim Form

Jubilee HEALTH TAKAFUL

For Office Use Only							
Registeration No.		Document No.		Membership No.		Issue Count	

Section A- To be filled in by the Claimant/Patient

1. Name of the Company / Participant
2. Name of the Claimant

(State the full & correct name in which cheque has to be prepared in case of reimbursement, if the beneficiary is an employee)

3. Name of the Claimant's Father / Spouse
4. Full Address of Claimant
5. Full Name of the Patient
6. Date of Birth of Patient ☐☐/☐☐/☐☐☐☐ ☐ MALE ☐ FEMALE
7. CNIC No. ☐☐☐☐☐-☐☐☐☐☐☐☐-☐
8. Membership Number ____ Certificate #: ____ Phone Number: ____
9. Patient's Relationship to Claimant ☐ Employee ☐ Dependent Total Amount Claimed in Rs. : ____
10. State the nature of illness/injury/Medical Condition
11. State the date at which symptoms first occur
12. The Patient last working day
13. Name the hospital from where the treatment has been taken for present condition
14. Address of the hospital
15. Name of the Doctor
16. If we require an independent medical examination at which address the patient would be located: ____

I, the above claimant, certify that all answers and all documents submitted with the form are complete and true to the best of my knowledge and beleif. I, hereby authorize any doctor, hospital clinic, medical provider, company, institution or any other person who has any record/information about me or my family members to provide Jubilee Health Takaful for this claim. Any photocopy of this declaration/authorization shall be taken as original copy.

Signature of the patient (If the patient is under 18 (minor) the claimant should sign)	Signature & stamp of the Employer	Date (dd/mm/yyyy)

To be filled in case of Reimbursement if the beneficiary is an employee	
Bank Name with Branch Name	
Location of Branch	
Bank Account number	