**Jubilee**

**GENERAL INSURANCE**

Jublee General Insurance Company Limited

(formerly New Jublee Insurance Company Limited)

2nd Floor, Jublee Insurance House, I.I Chundrigar Road, Karachi – 74000

UAN: 111 654 111, Tel: (021) 32416022-26, FAX (021) 32425774, 32438738

E-mail: [Info@jubleegereral.com.pk](mailto:Info@jubleegereral.com.pk), Website: [WWW.Jubleegeneral.com.pk](http://WWW.Jubleegeneral.com.pk)

**CLAIM TYPE**

**Health Insurance Division** INPATIENT PRE/POST

**SECTION I**

**(TO BE COMPLETED BY EMPLOYEE)**

Company Name: **Bahria University** Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy No. 0**5932** ID: Comp ID \_ Amount of Claim **Rs.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the above named employee, declare that the information given in this form is correct to the best of my knowledge, I hereby authorize any Hospital or Doctor / Surgeon who has attended to me or to my family member to furnish to The Jublee General Insurance (The Company) any Information they may require concerning our medical history, examination or treatment etc.

Employee Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: **2018**

**SECTION II**

**(TO BE COMPLETED BY ATTENDING PHYSICIAN/SURGEON)**

Name of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ **Years**

Name & Address of Referring Doctor (If any) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name or Physician/Surgeon: ­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mobile No.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PMDC No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Hospital & Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone No.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Source of Admission: Emergency Elective/Planned Other

Patient Registered as: Bed Patient Outpatient

Date of Admission \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Discharge \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Presenting Complaints & duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Associated Disease & Duration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Medical /Surgical History with Diagnosis & Durations \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Operation (if applicable) **\_\_\_\_\_\_** Final Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment Given during hospitalization including detail of all investigations and medications: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Doctor’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital Seal and Authorized Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: 2018

**SECTION III**

**Name of Patient Sheeraz Age: 24 Years**

**Name & Address of Referring Doctor (If any) N.A**

014

**(VERIFICATION BY POLICY HOLDER / EMPLOYER)**

**PLEASE ENSURE COMPLETION OF SECTION I & II**

**Name of** Employer **Bahria University** Policy No. 5932

Employee Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OIC Health Insurance / HOD Signature with Seal\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name / Designation of Authorized Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Company Seal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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