Jubilee
INSURANCE

MEDICAL INSURANCE CLAIM FORM

Serial No.

The Jubilee Insurance Company of Uganda Limited
HEAD OFFICE:
Jubilee Insurance Centre, Plot 14, Parliament Avenue
P. O. Box 10234, Kampala Uganda
Tel: 0414 311701/ 0312 260899, Fax: 0414 347 787
Email: jicug@jubileeuganda.com

DIRECTIONS:

1. *Date and sign the claim form and ensure that the same is signed and stamped by the Doctor.*
2. *Incomplete claim form will not be processed/paid.*
3. *No claim form will be considered if submitted after 90 days from the date of illness.*

NAME OF SERVICE PROVIDER _____ **DATE** _____

PERSONAL (PATIENT'S) INFORMATION:

Company/Scheme Name _____ Tel. No. _____

Employee Name _____ Medical Card No. _____

Patient Name _____ Sex _____ Date of Birth _____

Relationship: Employee ☐ Spouse ☐ Child ☐ Other *(Specify)* _____

MEDICAL INFORMATION: *(Doctor to complete this section)*

What was the nature of illness/injury/complaint which the patient suffered? _____

Diagnosis _____

The above condition is: Acute ☐ Chronic ☐ Congenital ☐ Dental ☐ Optical ☐

Any previous history of this condition? Yes ☐ No ☐

State any underlying condition which could result in this illness/injury? _____

Was the patient referred to a specialist? If yes, provide details of the specialist? _____

Consultation Fee _____

Investigations (Laboratory/X-Rays/ Other Diagnostic Tests)	Cost
1.	
2.	
3.	
4.	

Other Services (e.g. Dressing, I&D, etc.)	Cost
1.	
2.	
3.	
4.	

Drug prescribed/Treatment	Dose	Route	Frequency	No. of days	Cost	Total
1.						
2.						
3.						
4.						
5.						

Grand Total _____

CERTIFICATION BY MEDICAL PRACTITIONER:

I certify that the above information regarding this patient is true to the best of my knowledge and expense incurred are as a result of accident, illness reffered to.

Doctor's Name:..... **Qualification:**.....

Signature:..... **Date & Official Stamp:**.....

PATIENT'S DECLARATION *(Patient or Parent MUST sign below)*

I hereby confirm that the information given is accurate, correct and in accordance with the medical scheme rules. The undersigned authorizes the Hospital/Clinic to furnish Jubilee with such information, as Jubilee may deem necessary in connection with any treatment or other services provided. ***PLEASE CONFIRM YOUR FINAL BILL BEFORE SIGNING.***

Signature of Patient or Parent *(if patient is a minor)*..... **Date:** ...../...../20.....

Thank you for choosing Jubilee Insurance Company of Uganda Limited!