

Adamjee Insurance Company Limited

Health Window takaful Claim Form



INSTRUCTIONS: (Please read them carefully)

1. In order for us to provide you with efficient services, please complete the form accurately in "CAPITAL LETTERS"
2. Filled forms should be sent to Adamjee Insurance Company Limited within 30 days of the expense incurred date.

Employee Details (To Be Filled by the Employee)

Name of Employee: _____ Bank Account Title: _____
 Name of the Patient: _____ Relation with Employee: _____
 Name of the Company: _____ Auth Letter No.: _____
 Employee ID: _____ Contact #: _____ CNIC #: _____ -- _____ -- _____

Note: Please attach the copy of your updated health card at top of the claim

Out Patient Claim (OPD)

Documents Attached with the Claim	Sr #	Patient Name	Relation with Employee	Amount (PKR)
<input type="checkbox"/> Bill(s) (Original)				
<input type="checkbox"/> Prescription(s) (Copy)				
<input type="checkbox"/> Lab Report(s) (Copy)				
Total Amount Claimed				

Note: In case of more space required attach another claim form.

Hospitalization / Pre & Post Hospitalization Claim (IPD)

Documents Attached with the Claim <input type="checkbox"/> Hospital Bill (Original) <input type="checkbox"/> Discharge Summary (Copy) <input type="checkbox"/> Birth Certificate (In case of Birth) <input type="checkbox"/> Lab Reports (Copy) <input type="checkbox"/> Pharmacy Bills (Original) <input type="checkbox"/> Prescription (Copy)	<input type="checkbox"/> Hospitalization <input type="checkbox"/> Maternity <input type="checkbox"/> Pre / Post Hospitalization
	Name of Hospital: _____ Name of Treating Doctor: _____ Date of Admission: _____ Date of Discharge: _____
	<input type="checkbox"/> Emergency <input type="checkbox"/> Elective Has the claimant suffered from this illness before? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Claimed Amount:

Disclaimer: Please note that In Case of any of the above document missing the claim will not be processed.

DECLARATION:	To be filled by attending physician/hospital (In Case of HOS/MAT)
I hereby declare that all the information furnished in this claim form is true and correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize Adamjee Insurance Company Limited, to seek necessary medical information / documents from any hospital / medical practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim in accordance to the checklist mentioned and that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any. Any photocopy of this declaration shall be taken as the original copy.	Patient's Name: _____ Final Diagnosis: _____ Procedure: _____ I hereby certify that my answers to the above questions are correct and true to the best of my knowledge and belief:
Signature of the Employee _____	Signature/Stamp of the HR _____ Mobile No. & Address _____ Signature/Stamp of Doctor _____

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