Jubilee INSURANCE

J CARE CLAIM FORM

Please answer all questions fully. Please attach all bills, receipts and credit/Debit card slips pertaining to your claim.
All valid claims shall be submitted to JUBILEE INSURANCE within a maximum of 3 months of receiving treatment failing which the claim will not be paid.
Please attach all original invoices and proof of payment issued by the medical practitioner or pharmacy.

1. Main Member Details:

First Name :	
Last Name :	
Date of Birth:	D D M M Y Y Y Y
Employer Name :	
Telephone No:	
Address :	
Email address :	

2. Claimant Details :

Membership Number(As on your health Card) :	
Relationship with main member	
Title :	Mr. ☐ Mrs. ☐ Ms. ☐
First Name:	
Last Name:	
Date of Birth:	D D M M Y Y Y Y
Present completed age:	*(Yrs)*
Do you have another health benefit plan?	

3. Please select the type of treatment undergone (Please tick):

Medical : ☐ Surgical: ☐

Consultation ☐ Generalist ☐ Specialist ☐

Dental : ☐ Acute Medicines: ☐ Chronic Medicines: ☐ Optometry : ☐ Test and Procedures: ☐

Maternity: ☐ Normal Delivery: ☐ Caesarian: ☐

All questions must be answered by the claimant :

Total Amount Claimed :	Rs.
State Nature of treatment or injuries suffered :	
Date of treatment :	D D M M Y Y Y Y
Name of medical practitioner:	Dr.
In Case of admission :	Date admitted : D D M M Y Y Y Y Date of discharge : D D M M Y Y Y Y
Name of Clinic at which treatment undergone :	
Number of pages of detailed bills attached :	
No. of pages of medical report if any :	

5. Confirmation Declaration :

I, hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment information, my right to claim reimbursement of the said expenses shall be absolutely forfeited.

I also consent & authorise JUBILEE INSURANCE (MAURITIUS) LTD to seek medical information from any clinic / medical practitioner who has at any time attended on me.

I hereby authorise any clinic, physician or other person who has treated , attended or examine me to furnish the insurer or its authorised representative any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment including copies of relevant or medical records.

Signature of claimant: _____ DATE: _____

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