

# **The Medical Fund of**



**Siri Guru Singh Sabha  
Mombasa, Kenya**

**P.O. Box 84566  
Mombasa – 80100**

**The Byelaws  
May 2024**



The Byelaws of The Medical Fund  
of Siri Guru Singh Sabha, Mombasa  
P.O. Box 84566, Mombasa-80100, Kenya.

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**IN EXERCISE** of the powers conferred by clause 8.7 of the Constitution of the Medical Fund of Siri Guru Singh Sabha Mombasa, the Management Committee hereby makes the following Byelaws:

**1. NAME**

These Byelaws shall be called The Medical Fund of Siri Guru Singh Sabha Mombasa (Benefits and Claims) Byelaws 1994 and as amended on 06<sup>th</sup> April, 2022 and shall come into operation with effect from 01<sup>st</sup> May, 2022

**2. SCOPE OF THE MEDICAL FUND**

- 2.1** The Medical Fund shall reimburse medical expenses as laid out for In-Patient and Out-Patient treatment in any Hospital registered as such under the relevant legislation of the Country and designated from time to time by the Management Committee where members of the Medical Fund may obtain treatment.
- 2.2** Claims from Institutions outside Kenya utilized by members will be at the discretion of the Management Committee who shall ensure that the Institution is duly recognized by the relevant Medical body of that Country.
- 2.3** The maximum charges per day for Private Room shall be up to Kshs 10,000.00, Intensive care unit up to Kshs 15,000.00 and Day Care in Hospital/Clinic up to Kshs 5,000.00. All extras and luxuries such as suite, telephones, video-cassettes etc. shall be borne by the member.
- 2.4** All laboratory or other investigative procedures as laid out and as required by the Medical Practitioner whether done as an In-Patient or Out-Patient for diagnostic purposes.
- 2.5** Fees for the Surgeon, Physician, Anaesthetist or any other Specialist both as In-Patient or Out-Patient as laid out and according to an approved Scale adopted by the Committee.
- 2.6** The fees for General Medical Practitioner both for In-Patient and Out-Patient as laid out and according to an approved scale adopted by the Committee.
- 2.7** Expense for medication on authorised prescriptions from a Medical Practitioner as laid out.

### **3. MAXIMUM BENEFITS AND EXEMPTIONS**

- 3.1** The maximum medical benefit excluding chronic illness medicines, emergency dental, dental and optical per year per individual member shall not exceed Kshs 250,000.00. The ceiling may be reviewed by the Committee and shall be binding to all members. In the event of a critical illness Kshs 200,000.00 shall be added to the prevailing maximum benefit.
- 3.2** The Members minimum contribution to any one claim shall be as follows:
- 3.2.1** 20% in case of In-Patient and Out-Patient.
- 3.2.2** 20% in case of doctors & specialists In-patient and Out-Patient fees.
- 3.2.3** The percentage of retail price payable by members for chronic illnesses essential treatment medicines including supplements and vitamins shall be 60% for all members.
- 3.2.4** Emergency Dental treatment.  
(Maximum benefit limit shall be Kshs 20,000.00).
- 3.2.5** 50% for other Dental treatment excluding cosmetic e.g. cleaning/polishing.  
(Maximum benefit limit shall be Kshs 50,000.00).
- 3.2.6** 50% for Optical care.  
(Maximum benefit limit shall be Kshs 30,000.00).
- 3.3** Notification of hospitalisation shall be within 48 hours of admission to any member of the Management Committee by any means but the committee reserves the right to inquire if admission is genuine.
- 3.4** Self-inflicted injuries or illnesses including suicide, attempted suicide, treatment for alcoholism and drug abuse shall be exempted.
- 3.5** Benefits received by members from other insurance's, employment medical schemes, workmen compensation, National Hospital Insurance Fund shall be deducted from the claim.
- 3.6** Any member not covered by NHIF shall be responsible for the payment of the amount equivalent to the NHIF refund per hospital bed, except those exempted by the NHIF rules.
- 3.7** Cosmetic surgery (except when necessitated by injury or accident) and treatment undertaken in nature cure clinics including nursing homes, acupuncture, etc. shall not be eligible for claim.

- 3.8 Injury or illness resulting from participation in extreme sports like, motor sports, skiing, parachuting and diving are exempted. Participants are encouraged and do require Special Insurance cover.
- 3.9 Stays at sanatoriums, old age homes are exempted.
- 3.10 Transport costs including ambulance and air-fare are exempted.
- 3.11 Costs of treatment for infertility or impotence are exempted.
- 3.12 Mortuary charges and Last offices are exempted.

#### **4. CLAIMS**

- 4.1 All claims must be submitted to the Treasurer/Claims Officer appointed by The Committee for such purposes within 90 days from the date of First Visit for out-patient and date of discharge for in-patient.
- 4.2 All claims must be submitted in writing and on prescribed forms and accompanied by all original receipts giving full breakdown details.
- 4.3 Subject to proper submission of claims, these will be processed within 30 days from the date of submission and if approved settled within the next 30 days.
- 4.4 Payment for all In-patient and Out-patient claims will be paid directly by the member and then claimed from The Medical Fund.
- 4.5 In exceptional cases, any monies for claims due to the Medical Fund must be honored by the member within 45 days. Where it is delayed it will attract interest at 5% above the rates the Medical Fund earns at that given time for a maximum period of 3 months, thereafter, the membership shall be suspended till all dues are paid.
- 4.6 Should the settlement of a claim after an appeal to the Management Committee, be unsatisfactory to the claimant, the said claim will be referred to the Board of Trustees, whose decision will be final and binding.
- 4.7 Notwithstanding 4.1 above members treated overseas shall submit claims within 30 days of their arrival in the country.

**5. REIMBURSEMENT SCALE FEES:**

**5.1. GENERAL PRACTICE:**

5.1.1	Consultation	Kshs	1,800.00
5.1.2	House Visit		3,600.00
5.1.3	In-Patient per visit maximum 2 per day		3,600.00

**5.2. SPECIALIST PRACTICE:**

5.2.1	Consultation		3,600.00
5.2.2	In-Patient ICU daily per visit max 2 per day		6,000.00
5.2.3	In-Patient daily per visit max 2 per day		5,400.00

**5.3. MEDICAL PROCEDURES:**

5.3.1	ECG & Report		1,800.00
5.3.2	Executive Check 50% or maximum per annum		20,000.00
5.3.3	Monitoring tests for chronic ailments e.g., HbA1c		50%
5.3.4	Chemotherapy procedures Doctors fees.		18,000.00
5.3.5	Procedures not stated here at the discretion of Management committee.		

**5.4. THEATRE CHARGES & SURGICAL OPERATIONS  
CONSOLIDATED REIMBURSEMENT FEE:**

5.4.1	Theater charges for two hours		30,000.00
5.4.2	Surgical procedures in Minor Theatre		25,000.00
5.4.3	Diagnostic Procedures		25,000.00
5.4.4	Minor		30,000.00
5.4.5	Medium		35,000.00
5.4.6	Medium Plus		40,000.00
5.4.7	Major		50,000.00
5.4.8	Major Plus		70,000.00
5.4.9	Regional		90,000.00
5.4.10	Special Defined Cases		as Stated below:

<b>SURGERY</b>	<b>FEE</b>	<b>SURGERY</b>	<b>FEE</b>
Skull & Brain Operations	90,000.00	Renal Operations	54,000.00
Spinal Cord Op	60,000.00	Renal Op Bilateral	72,000.00
Spinal Cord Microsurgery	72,000.00	Urinary System Op	54,000.00
Thyroid Op	42,000.00	Prostate Operations	54,000.00
Corneal Transplant	42,000.00	Testicular Operations	30,000.00
Glaucoma Op	36,000.00	Ovarian Operations	42,000.00
Cataract Extraction	36,000.00	D & C & Cervical Op	24,000.00
Cataract Lens Implant	42,000.00	Normal Delivery	36,000.00
External Ear	24,000.00	Assisted Delivery	42,000.00
Middle Ear	30,000.00	Caesarean Section	54,000.00
Inner Ear	36,000.00	Laparoscopy	36,000.00
Sinus Operations	30,000.00	Uterus Operations	60,000.00
Tongue Operations	30,000.00	Closed Fracture Reduce	30,000.00
Tonsil & Adenoids	30,000.00	Open Fracture Reduce	54,000.00
Larynx Trachea Op	36,000.00	Internal Plating	60,000.00
Lung Operation	42,000.00	Internal Fixation Multi	72,000.00
Blood Vessel Operation	36,000.00	Hip Surgery	90,000.00
Heart Operations	90,000.00	Other Joint Surgery	48,000.00
Oesophageal Operations	36,000.00	Tendon Repairs	30,000.00
Gastric Operations	36,000.00	Amputation Limb	60,000.00
Intestinal Operations	42,000.00	Amputation Digits	36,000.00
Appendix Operations	30,000.00	Breast Diagnostic	18,000.00
Rectal? Perirectal Op	36,000.00	Breast Mastectomy	60,000.00
Biliary Tract Operations	42,000.00	Skin Grafts	30,000.00
Hernia Repairs Single	42,000.00	Laparoscopic surgery	72,000.00
Hernia Repairs Bilateral	54,000.00	Abdominal Operations	48,000.00

**5.5. ANAESTHETIST:**

- 5.5.1 Routine 1/3rd Surgeons fees as above.
- 5.5.2 Major 1/3rd Surgeons fees as above.

**5.6 PHYSIOTHERAPY:**

A fee of Kshs 2000.00 per session shall be reimbursed for prescribed physiotherapy. Reimbursement for cost of implements prescribed by the physiotherapist shall be 50% of its retail price.

**5.7 GENERAL:**

- 5.7.1 The Medical Fund's Liability is 80% for both In-patient and Out-patient claim, but not exceeding the above approved maximum benefit scale. Balance 20% and or any excess to be borne by the member.
- 5.7.2 Notwithstanding the above, The Medical Fund shall reimburse 100% of Out-Patient and Day Care treatment at Siri Guru Nanak Clinic.
- 5.7.3 The Management Committee has the right to determine each case individually into any of the above categories and the above shall be a guideline only.

**6. DISCRETIONARY POWERS**

In addition to all powers expressly conferred upon the Management Committee under the Constitution and Byelaws, the Management Committee shall have the following “Discretionary Powers”.

These powers are to be exercised by the Management Committee by simple majority if not unanimous in its decision at its sole discretion. The objects of the powers are to provide extra medical benefits when necessary to the members when under the Byelaws of the Medical Fund no such assistance can be given to them.

- 6.1 Any two Office Bearers of Management Committee may jointly may at any time for the benefit of a member bind the Medical Fund to settling a hospital bill not in excess of Kshs 150,000.00 provided that this action is agreed upon by the member in writing to settle the hospital bill within 30 days of discharge and the action is ratified in the next Management Committee meeting.



Adopted by the members of the Management Committee of the Medical Fund of Siri Guru Singh Sabha, Mombasa this 7<sup>th</sup> Day of August 1994.

First revision 9<sup>th</sup> Day of January, 1997.

Second revision 6<sup>th</sup> Day of November, 1997.

Third revision 1<sup>st</sup> Day of October, 1998.

Fourth revision 7<sup>th</sup> Day of January, 1999.

Fifth revision 2<sup>nd</sup> Day of March, 2000.

Sixth revision 31<sup>st</sup> Day of March 2008.

Seventh revision 31<sup>st</sup> Day of March 2010.

Eight revision 18<sup>th</sup> Day of January 2012.

Ninth revision 22<sup>nd</sup> Day of July 2014.

Tenth revision 09<sup>th</sup> Day of May 2018.

Eleventh revision 06<sup>th</sup> Day of April 2022.

Twelfth revision 24<sup>th</sup> Day of May 2024.

Signed on their behalf:

**S. SATNAM SINGH BHABRA.**  
**CHAIRMAN MANAGEMENT COMMITTEE 2021-24**  
**THE MEDICAL FUND OF SIRI GURU SINGH SABHA, MOMBASA.**

**THE MEDICAL FUND OF SIRI GURU SINGH SABHA, MOMBASA**  
**P.O. BOX 84566, MOMBASA – 80100, KENYA.**

**OUT PATIENT MEDICAL EXPENSE CLAIM FORM**

Patient's Name:

Membership No:

**To be completed by the Medical Attendant**

[A] Date of 1<sup>st</sup> Visit:

Diagnosis:

Number of Consultations:

Dates:

Charge per Consultation:

Total for Consultations:

Charge per House Visit:

Total for House Visits:

[A] Total for Consultations & House Visits:

**Kshs**

[B] Medicines / Injections dispensed by the Doctor and or by the Chemist.

Doctor. should provide details of medicines dispensed / prescribed below:

ITEM & QUANTITY	COST	ITEM & QUANTITY	COST
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Attach prescription copy and original receipts from Doctor and or Chemist.

[B] Total for Medicines / Injections:

**Kshs**

[C] Investigations carried out by the Doctor and or at an Institution.

Doctor should provide details below:

INVESTIGATION	COST	INVESTIGATION	COST
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Attach copy of request form and original receipts from Doctor and or Institution.

[C] Total for Investigations:

**Kshs**

[D] List any procedures carried out.

**Charges.**

1.

2.

[D] Total for procedures:

**Kshs**

**Grand Total for Out Patient Treatment{A+B+C+D}**

**Kshs**

**IMPORTANT NOTES:**

1. All claims must be submitted **within 90 days** of your 1<sup>st</sup> Visit to the Doctor.
2. Copies of prescriptions and request forms must be attached.
3. Original receipts **must** be attached. Photocopies or certified copies are **NOT** acceptable.

**MEDICAL CERTIFICATE:**

The above named suffered from the illness detailed herein and all costs incurred are for the illness.

**Doctor's name:**

**Doctor's rubber stamp:**

**Dr. Signature & Date**

**DECLARATION BY PATIENT / GUARDIAN:** The undersigned, authorizes and requests any Doctor, Hospital or Health Provider to furnish The Medical Fund or its duly authorized agents acting on behalf of The Medical Fund, with any such information that is sought in connection with any treatment and or services provided to me or my dependent for the purpose of processing this claim.

**ALL information will be kept confidential by The Medical Fund / Agent.**

**Signature & Date**

**THE MEDICAL FUND OF SIRI GURU SINGH SABHA, MOMBASA**  
**P.O. BOX 84566, MOMBASA – 80100, KENYA.**

**FOR OFFICIAL USE ONLY**  
**OUT PATIENT MEDICAL EXPENSE CLAIM PROCESSING FORM**

Date Claim Form Received:	
Received by:	
Claim Form Receipt Number:	<b>OP:</b>
Claim Form Processed by:	
Date of 1 <sup>st</sup> Visit:	
<b>Total Expenses Claimed:</b>	<b>Kshs:</b>

Item	Amount Claimed	Retail Price/Scale	% Due / Scale	Amount Payable
[A]				
[B]				
[C]				
[D]				
<b>Totals</b>				

Total amount due as per working {A+B+C+D}	<b>Kshs.</b>
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Approved by Management Committee Date of Meeting:	Signatures of 2 Committee Members:
Date Paid:	
Cheque number:	
Claim Form Register number:	
<b>Treasurer's Signature:</b>	

Special Comments If Any for Future Claims:

Redrafted March 2008. Supersedes All Previous Forms.

**THE MEDICAL FUND OF SIRI GURU SINGH SABHA, MOMBASA**  
**P.O. BOX 84566, MOMBASA – 80100, KENYA.**

**IN PATIENT MEDICAL EXPENSE CLAIM FORM**

Patient's Name:

Membership No:

**To be completed by the Medical Attendant**

**Diagnosis:**

**[A] Hospital:**

Date of Admission:

Date of Discharge:

Bed charges per day:

Number of days

**[A] Total for bed charges:**

**Kshs**

NHIF number:

Rebate per day:

**[B] Total NHIF Claim for the admission:**

**Kshs**

**[C] Total for hospital accommodation charges {A – B}:**

**Kshs**

**[D] List below all other In-Patient charges and provide original receipts:**

DETAILS	CHARGES	DETAILS	CHARGES
1.		4.	
2.		5.	
3.		6.	

**[D] Total for other In-Patient charges:**

**Kshs**

**[E] List below all Doctor's charges and provide original receipts where applicable:**

DOCTORS	CHARGES	DOCTORS	CHARGES
1.		3.	
2.		4.	

**[E] Total for all Doctors charges:**

**Kshs**

**[F] List below any other Claimable charges and provide original receipts:**

DETAILS	CHARGES	DETAILS	CHARGES
1.		3.	
2.		4.	

**[F] Total for any other Claimable charges:**

**Kshs**

**[G] Discounts:**

**[G] Total for discounts:**

**Kshs**

**Grand Total for In-Patient Claim {C+D+E+F-G}**

**Kshs**

**IMPORTANT NOTES:**

1. All claims must be submitted **within 90 days** from the **date of discharge** from Hospital.
2. Details / Breakdowns of drugs, surgicals, laboratory tests, X-rays/Scans and theatre materials must be attached.
3. Original receipts **must** be attached. Photocopies or certified copies are **NOT** acceptable.

**MEDICAL CERTIFICATE:**

The above named was admitted for the illness detailed herein and all costs incurred are for the admission.

**Doctor's name:**

**Doctor's rubber stamp:**

**Dr. Signature & Date**

**DECLARATION BY PATIENT / GUARDIAN:** The undersigned, authorizes and requests any Doctor, Hospital or Health Provider to furnish The Medical Fund or its duly authorized agents acting on behalf of The Medical Fund, with any such information that is sought in connection with any treatment and or services provided to me or my dependent for the purpose of processing this claim.

**ALL information will be kept confidential by The Medical Fund / Agent.**

**Signature & Date**

Redrafted March 2008. Supersedes ALL Previous Forms.

**THE MEDICAL FUND OF SIRI GURU SINGH SABHA, MOMBASA**  
**P.O. BOX 84566, MOMBASA – 80100, KENYA.**

**FOR OFFICIAL USE ONLY**  
**IN PATIENT MEDICAL EXPENSE CLAIM PROCESSING FORM**

Date Claim Form Received:	
Received by:	
Claim Form Receipt Number:	IP:
Claim Form Processed by:	
Date of Discharge:	
<b>Total Expenses Claimed:</b>	<b>Kshs:</b>

Item	Description	Amount Claimed	% Due / Scale	Amount Payable
[A]	Bed charges			
[B]	Less NHIF			
[C]	<b>Total for hospital bed charges payable {A – B}: Kshs</b>			

[D]	<b>Other In-Patient charges</b>			
Item	Description	Amount Claimed	% Due / Scale	Amount Payable
1.				
2.				
3.				
[D]	<b>Total for other In-Patient charges payable: Kshs</b>			

[E]	<b>Doctors Charges:</b>			
	Doctor	Amount Claimed	Discount	Amount Payable
1.				
2.				
[E]	<b>Total for Doctors charges payable: Kshs</b>			

[F]	<b>Any other Claimable charges</b>			
	Description	Amount Claimed	% Due / Scale	Amount Payable
1.				
2.				
[F]	<b>Total for any other Claimable charges payable: Kshs</b>			
[G]	<b>Less Total discount obtained from hospital: Kshs</b>			
[H]	<b>Grand Total Payable for In-Patient {C+D+E+F-G}: Kshs</b>			

Approved by Management Committee Date of Meeting:	<b>Signatures of 2 Committee Members:</b>
Date Paid:	
Cheque number:	
Claim Form Register number:	
<b>Treasurer's Signature:</b>	
Special Comments If Any for Future Claims:	

**THE MEDICAL FUND OF SIRI GURU SINGH SABHA, MOMBASA**  
**P.O. BOX 84566, MOMBASA – 80100, KENYA.**

**REQUISITION FORM FOR DISPENSING CHRONIC ILLNESS MEDICINES**

**ALL information will be kept confidential by The Medical Fund / Agent.**

**Chronic illness medicines** as stated herein will be purchased for the member and supplied by the Management Committee of The Medical Fund through its appointed agent as per Byelaw:

**3.2.3** The percentage of retail price payable by members for chronic illnesses medicines shall be as follows:  
60% for members of all ages.

**CONDITIONS OF PURCHASE:**

1. Only those medicines as prescribed below by the Doctor will be dispensed.
2. The Medical Fund nor its appointed agent can be held responsible for any misuse of drugs dispensed.
3. Members must verify the nature, quantity and expiry dates of medicines dispensed.
4. Medicines once dispensed cannot be returned under any circumstances whatsoever.
5. The Medical Fund and or its appointed agent reserve the right to dispense the justified quantity of medicines.
6. All medicines dispensed are strictly on cash basis.
7. The Medical Fund will adhere strictly to the recommended retail price of the drugs.

Member's name:

Membership No:

Patient's name:

Telephone contact:

**List of chronic illness medicines prescribed**

<b>No:</b>	<b>Name of Medicine</b>	<b>Strength</b>	<b>Dosage</b>	<b>Duration</b>
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

**MEDICAL CERTIFICATE:** This is to certify that the above-named patient has been prescribed the above-named medicines at the stated strength, dosage and duration as indicated by me.

**Doctor's name:**

**Doctor's rubber stamp:**

**Dr. Signature & Date**

**DECLARATION BY PATIENT OVER 18 YEARS OR**

**PARENT/GUARDIAN FOR CHILDREN UNDER 18 YEARS:**

1. I the above-named patient/parent/guardian certify that I am conversant with the medicines stated herein by the doctor and that I or the patient do take them regularly at the prescribed dosages.
2. I further agree to adhere to the conditions of purchase as stated above.
3. The undersigned, authorizes and requests any Doctor, Hospital or Health Provider to furnish The Medical Fund or its duly authorized agents acting on behalf of The Medical Fund, with any such information that is sought in connection with any treatment and or services provided to me or my dependent for the purpose of processing this claim.

**Signature & Date**

**Redrafted May 2024. Supersedes All Previous Forms.**

## NOTES

# **Our Mission**

**Every Sabha Member  
Should Be A Member of The Medical Fund**

# **Our Vision**

**To Provide Superb Medical Care  
At Affordable Cost World Wide To Our Members**

# **Our Appeal**

**“Please Support The Medical Fund  
Join Today”**