HEALTH CARE INSURANCE
Inpatient Medical Claim Form

Jubilee LIFE INSURANCE

Section A-To be filled in by the Claimant/Patient

1. Name of the Company / Policy Holder: Indus University
2. Name of the Claimant: Usman Mustafa Khawar

(State the full & correct name in which cheque has to be prepared in case of reimbursement, if the beneficiary is an employee)

3. Name of the Claimant's Father / Spouse: Khawar Rasheed
4. Full Address of Claimant:
5. Full Name of the Patient: Usman Mustafa Khawar
6. Date of Birth of Patient: 15/03/1992 ☑ MALE ☐ FEMALE
7. CNIC No.: 42401-0482284-9
8. Policy Number: 104755 Certificate #: 0000236 Phone Number:
9. Patient's Relationship to Claimant: ☑ Employee ☐ Dependent **Total Amount Claimed in Rs.:** 50,000/-
10. State the nature of illness/injury/Medical Condition: Stomach Pain
11. State the date at which symptoms first occur: 01-09-2023
12. The Patient last working day: 01-09-2023
13. Name the hospital from where thetreatment has been taken for present condition: Agha Khan Hospital
14. Address of the hospital: H#R490 (1st Floor), Block 16, FB Area
15. Name of the Doctor: Usman Mustafa Khawar
16. If we require an independent medical examination at which address the patient would be located:
17. Is the patient entitled for any other insurance or medical benefit? If yes, please provide brief details:
18. Is this a continuation of previous or current treatment? If yes please give brief details:

I, the above claimant, certify that all answers and all documents submitted with the form are complete and true to the best of my knowledge and belief. I, hereby authorize any doctor, hospital clinic, medical provider, company, institution or any other person who has any record/information about me or my family members to provide Jubilee Life Insurance Company Limited for this claim. Any photocopy of this declaration/authorization shall be taken as original copy

Signature of the patient (if the patient is under 18 (minor) the claimant should sign	**Signature & Stamp of the Employer**	**Date (dd/mm/yyyy)**

To be filled in case of Reimbursement if the beneficiary is an employee

Bank Name with Branch Name	
Location of Branch	
Bank Account number	