TAKAFUL
INSURANCE OF AFRICA
A bond beyond insurance

TAKAFUL CLAIM FORM

Name of Hospital ..... Tel & Fax No .....
Name of Medical Scheme Provider ..... Tel & Fax No .....
Name of Company/Client .....
Policy No. .....
Identification /Membership No. .....
Employee's Name: ..... Staff No. (if available) .....
Patient's Name: ..... Date of Birth: .....
Relationship to Employee: .....
Final Diagnosis of illness Treated: .....
When was the condition first diagnosed: .....

SICKNESS

Cause of illness/es: .....

Nature of treatment and given recommendations: .....

.....

ACCIDENTS

i. Date of Accident: ..... Cause of Accident: .....

ii. Nature of injuries: .....

I hereby confirm that the information provided above is correct and true to the best of my knowledge.

Date: ..... Doctor's Signature & Stamp: .....

I ..... do hereby authorize any doctor, hospital, clinic or medical provider, any other company, institution or person who has record or information about me and / or my family members to provide my insurer with complete information including copies of their records with reference to my sickness or accident any treatment, examination, advice or hospitalization. In the event that I access service which is not covered by my scheme or in the event that my scheme fails to pay the bill, I undertake to settle the bill in full within the provider's credit terms.
I have also been advised by ..... and have understood the various exclusions. Any photocopy of this authorization shall be taken as the original copy.

I WILL SUBMIT MY NHIF CARD (if NHIF Contributor) within 24 hours from time of the admission.
Patient/Parent/Guardian's Name (PRINTED): ..... Cell phone no: .....

Patient/Parent/Guardian's Signature: ..... Date: .....

Takaful Insurance of Africa
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