الخليجية للتكافل
Gulf Takaful

الشركة الخليجية للتأمين التكافلي
Gulf Takaful Insurance Company
شركة خاضعة لأحكام الشريعة الإسلامية
الشرق ، شارع الشهداء – بناية التأمينات الاجتماعية سابقا
تلفون : 1820202 فاكس : 22320243
e-mail : medical@gulftakaful.com

رأس المال المصرح به والمدفوع 15,000,000 د.ك Authorized & Paid Capital K.D. 15,000,000
شركة خاضعة لأحكام قانون شركات ووكلاء التأمين رقم (24) لسنة 1961 رقم الإجازة (31)

MEDICAL INSURANCE SCHEME
CLAIM FORM

Policy No. _____

PART 1

Patient's Membership No. _____

Group Member's Name (Mr./Mrs/Miss.) _____

Policyholder : _____

Patient's Name (if not Group Member) _____

Patient's date of birth _____

If Patient is not the Group - Member, tick relationship : -

Wife ☐ Husband ☐ Child ☐

For an in-patient stay in hospital, please enter date (s) of admission and discharge.

Admission Date _____ Discharge Date _____

Is the cost of this treatment also covered by any other Insurer ? Enter either YES or NO

Was the treatment necessary as the result of an accident ? Enter either YES or NO

If the answer to either question is YES, please give full details.

COMPLETE PART 1 OF THIS FORM :
Part 2 must be completed by the doctor / specialist giving details of treatment received. Submit this form with original account(s) within 90 days of the expenditure being incurred.

Your claim will not be considered if not submitted within the above Period.
A NEW CLAIM FORM IS REQUIRED EACH TIME YOU SUBMIT ACCOUNTS.

I hereby claim for costs of treatment and declare that, to the best of my knowledge and belief, all information given in support of this claim is true and complete.

Group Member's Signature _____ Date _____

Part 2
To be completed by Doctor/Specialist who carried out the treatment

Please complete this form in BLOCK CAPITALS

Conditions requiring treatment / Complaints _____

Date of Commencement of illness : _____

Date of first treatment : _____

Investigations _____

Medicines Prescribed : _____

Final Diagnosis : _____

Home Visit Hospital Call	Specialist/ Consultation	Medication/ Injection	LAB/X-RAY	Maternity	Hospital A/C (Attached)	TOTAL CHARGES

Doctor / Specialist's Signature / Stamp _____ Date _____

Note : Please attach originals of all relevant invoices, receipts and prescriptions. The amounts not supported by original documtes shall not be considered a part of your claim.