HOSPITALISATION CLAIM FORM

SECTION A: CLIENTS DETAILS

NOTE:
To be completed by the policy holder

The issuance of this form does not constitute an admission of liability under the policy. Should this claim be approved the payment will automatically be transferred to your account details of which are indicated in part 7 below.

POLICY HOLDER	
Name:	
Postal Address:	
	Code:
Cell:	
Tel (Daytime):	Fax:

1. POLICY NUMBER(S)

2. PATIENT
Name:
Date of Birth:
Relationship to Policyholder:
Occupation:
Tel. No:

SECTION B: HOSPITALISATION DETAILS

NOTE: To be completed by attending physician

3. GENERAL PRACTITIONER (USUAL FAMILY DOCTOR)	
Name:	
Postal Address:	
	Code:
Cell:	
Tel (Daytime):	Fax:

4. HOSPITAL		
Please attach copies of the hospital account.		
Name of Hospital:		
Tel No.	Fax:	
Attending Doctor:		
Tel No:	Fax:	
Admission date:		Time
Discharge date:		Time

5. REASON FOR HOSPITALISATION		
☐ Illness	☐ Pregnancy	☐ Accident

5a. DETAILS OF ILLNESS
Nature of illness:
When did patient become aware of illness?

5a. DETAILS OF ILLNESS (continued)
Has the patient suffered from this condition before?
If yes, give dates and details of treatment

5b. DETAILS OF PREGNANCY
Approximate date of conception:
Date of delivery:

5c. DETAILS OF ACCIDENT
Date of Accident:
Details of Accident:
Injuries sustained:

6. WAS HOSPITILISATION IN ANY WAY CONNECTED TO (applicable box)	Y	N
Conjenital conditions		
Chronic Defects / conditions		
Mental diseases or disorders		
Abuse of alcohol		
Drugs not administered on or in accordance with advice of a doctor Self inflicted injury/ attempted suicide		
HIV / AIDS related conditions / illness		
Miscarriage, abortion or any complication therefrom		
Details:		

7. ELECTRONIC FUND TRANSFER
Name of Bank / Building Society:
Account Holder's Name:
Account Number:
Type of Account
Branch Name:
Branch Code:

AIG, Eden Square Complex, Chiromo Road, P.O. Box 49460 - 00100 Nairobi, Kenya
Tel: 020 - 3676000 / 3751800, Fax: 020 - 3676001 / 2
E-Mail: aigkenya@aig.com Website: www.aig.com

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NOTE:
THIS SECTION NEED ONLY BE COMPLETED BY THE HOSPITAL IF NO ACCOUNTS ARE OBTAINABLE.
The policy holder is responsible for payment of any fee in connection the completion of this declaration.

DETAILS OF HOSPITAL	
Name:	
Postal Address:	
	Code:
Cell:	
Tel (Daytime):	Fax:

1. PATIENT
Name

2. REASON FOR HOSPITALISATION

3. DURATION OF HOSPITALISATION		
Admission date:	Time	
Discharge date:	Time	
Was the patient confined to an Hi-Care Unit? (applicable box) ☐	Intensive Care or	☐
Admission date:	Time	
Discharge date:	Time	
Admission date:	Time	
Discharge date:	Time	

4.	
Signature	Date
Name:	
Capacity:	Stamp

SECTION C: DECLARATION

i. **Privacy Statement**

By completing this form, you have provided AIG with your personal information. AIG is committed to protecting the integrity, confidentiality, access and use of personal information that we collect from you in the course of our business. "Personal Information" is information that identifies and relates to you or other individuals (such as your dependants). You have the right to access and correct personal data that may be incorrect or incomplete. I hereby authorize AIG to use my personal information for lawful business purposes. For more information on how we handle personal information kindly obtain a copy of our privacy policy from our office.

ii. **Declaration**

I/We declare that the above information is true and correct and that the signing of this claim form also constitutes written authority for AIG to inspect or investigate any medical records or details relevant to this claim. I/we further declare that i/we are aware that any misrepresentation and / or non-disclosure in respect of information provided herein shall render my/our claim null and void.

I/We hereby acknowledge the contents of the statements i and ii above.

Name:_____

Signature: _____ Date: _____

(If Corporate):

Name:_____ Designation _____

Company Stamp