



RE-IMBURSEMENT CLAIM FORM

Tanzania Head Office
Mlimani City Office Park, Building No.6,
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Dar es Salaam, Tanzania

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Email: info@assemble.co.tz

IMPORTANT NOTICE

1. This form must be fully completed by the insured.
2. No liability under the policy is admitted by issue of this form.
3. Neither owner nor driver must admit fault or liability for this incident
4. All questions on this form must be answered.
5. Repairs must not be authorized without prior written authority of the Insurers.
6. Any form of misrepresentation of the information/Non-disclosure may lead to the claim not being payable.

1	Member's Name			Mobile		
2	Member's No			Valid From:		To: <input type="text"/>
3	Date of medical services					
4	Name and address of the PPO					
5	Name and telephone number of the GP/Specialist (who treated you)					
6	Diagnosis (brief discription of the disease)					
7	Cost of treatment					
	a) Consultation					
	b) Lab test	Cost				
	c) Drugs/Medicine	Cost				
8	Total amount of the claim in figures					
	Total amount of the claims in words					
9	Surporting documents attached, please tick if attached					
	1. Prescription					
	2. Laboratory test					
	3. Diagnosis					
	4. Payment EFDs receipts					
10	Reason for cash payments, Please tick					
	1. Emergency					
	2. No membership card					
	3. No Assemble PPO					
	4. PPO on cash					

11. Bank Details

Bank Name; _____ Branch name: _____

Account Name: _____ Account Number _____

Or. M-PESA No: _____

12. I certify that the above information is correct and the truth

Signature : _____ Date: _____

13. Employer's certification

Name of the Employer: _____

Authorised person's signature: _____

Designation: _____ Official Stamp _____

FOR OFFICIAL USE ONLY

Checked By: Case Assessor: _____ Signature _____ Date _____

Verified By: Claims Assessor/ Supervisor: _____ Signature _____ Date _____

Approved By: Claims Manager: _____ Signature _____ Date _____

A co-payment of 10% will apply for all reimbursement claims except for emergency cases and cases necessitated by absence of Provider Network.

