Assemble
INSURANCE

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RE-IMBURSEMENT
CLAIM FORM

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:	
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.