SHREE VISA OSHWAL COMMUNITY

OSHWAL MEDICAL RELIEF SCHEME

P.O. BOX 40638 NAIROBI TEL: 3747689/2696293

CLAIM FORM

APPLICATION FOR RELIEF OF MEDICAL EXPENSES

1. PATIENT'S FULL NAME: _____
   (Including father's or husband's full name)

2. AGE ON DATE OF ADMISSION _____ CONTRIBUTOR NO: _____

3. BUSINESS NAME: _____

4. P.O. BOX _____ TEL. (OFF) _____ (RES) _____

5. NAME OF DOCTOR RECOMMENDING HOSPITALISATION _____

6. NAME OF HOSPITAL _____

7. DATE ADMITTED _____ DATE DISCHARGED _____ NO OF DAYS ___

8. NATURE OF ILLNESS _____

9. ARE YOU INSURED UNDER ANY OTHER POLICY? PLEASE GIVE DETAILS _____

_____

10. CHEQUE IN FAVOUR OF: _____

I declare that to the best of my knowledge and belief the particulars and information provided herein above are true and complete and I consent to the Oshwal Medical Relief Scheme seeking further information about this hospitalization from any doctor consulted by me and/or from the Hospital authorities.

Date: _____ Signature: _____

NB: PLEASE ATTACH ONLY THE ORIGINAL BILLS, FINAL INVOICES AND RECEIPTS IN SUPPORT OF THIS APPLICATION. PHOTOCOPIES, INTERIM INVOICES OR DUPLICATES ARE NOT ACCEPTABLE.

Received:

Hospital Bills	Original	
Doctors' Bills	Original	
Others	Original	

Required from: Name _____ Claim No: _____

Hospital Bill	Original	
Doctors' Bills	Original	
Others	Original	