EFU Health Insurance Limited
Window Takaful Operations

Claim Form

IMPORTANT INSTRUCTIONS: (please read them first)

I- In order for us to provide fast and efficient service, please complete the Form accurately in 'CAPITAL LETTERS'. Photocopies of this form can also be used.

II- Filled forms should be sent to: Claims Department, EFU Health Insurance-Window Takaful Operations, 37-K, Block-6, PECHS Society, Karachi within **30 days** of the expense incurred date. Please attach the following with the form:

a. Proper itemized bill(s) and payment receipt(s) as highlighted below. These should be issued on the official bill/receipt book of the Hospital/Physician/Surgeon/Pharmacy/Laboratory.

Proper hospital bill in original highlighting type of accommodation used (room type) and break up of total bill according to:
❶ Room charges ❷ Lab tests and Radiology Charges ❸ Consultation charges ❹ Surgeons fee with details (if any)
❺ Operation Theatre Charges (if any) ❻ Anesthesia charges (if any) ❼ Medicines (used during hospitalization)
❽ Other miscellaneous medical expenses like blood & oxygen, etc.

b. Laboratory, or Radiology reports along with doctor's reference for the same.

c. Itemized bill(s) of medicines purchased supported by Physician's prescription specifying the quantity and respective dosage.

d. Hospital discharge summary / Clinical Summary (in case of Hospitalization).

e. Copy of Birth Certificate (in case of delivery/child birth)

III- If you have any diffficulties filling this form, please call our Customer Relations Dept. at 111-HELP-000 (111-4357-00) Approved claim could be settled through direct bank transfer. Please provide following bank details for direct bank transfer.

To Be Completed by the Employee / Policy Holder:

Name of the Policy Holder: ______ Policy Number: ______

Name of the Employee: ______ Cert. Id: ______

Name of Patient: ______ Total Amount Claimed: **Rs.** ______

Date of Birth: ______ Relationship to the Employee: ______

Bank: ______ CNIC Number (if any): ______

Branch: ______ Department: ______

A/C. No: ______ Contact No: ______ Email: ______

Detail of New Born (s) in Case of Delivery /C-Section Claim:

Date of Birth: ______ Name: ______ Gender: ______

Declaration / Authorization:

I hereby certify that all answers, and all documents submitted with the claim form are complete and true. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance/takaful company or any company, institution or any other person who has any record or information about me and/or of my family members to provide EFU Health Insurance Limited-Window Takaful Operations, with the information, including copies of their records with reference to any sickness or accident, any treatment, examination, advice or hospitalization. Any photocopy of this declaration./authorization shall be taken as the original copy.

Signature of Patient (if 18 years or above, otherwise signature of the employee)	**Signature & Seal of the Employer** (For Corporate Schemes only)	**Date**

In case of Hospitalization:

Emergency Treatment or Elective? ____ Was pre-authorization taken? Yes ☐ No ☐

Date of Admission: ____ Date of Discharge: ____

Is the patient entitled to any other benefit or compensation from any other source whatsoever? If so name the companies or association, or other source, and give amount of benefit payable by each: ____

This portion must be completely filled in by the treating physician / Hospital. Any missing information shall lead to delay in claims settlement.

Patient Name: ____ Age ____ Gender ☐ Male ☐ Female

Name of Hospital ____

Date of Admission ____ Date of Discharge ____

Primary Diagnosis ____ Secondary Diagnosis ____

Presenting Complaints With Duration of Illness ____

Any Associated Disease / Co-morbids With Duration ____

Details of Surgical, Gynecological or Obstertrical Procedure Performed (If Any) ____

Indication / Necessity of Performing Surgical Procedure/ LSCS ____

Type of Anesthesia Used : ☐ General ☐ Local ☐ Spinal ☐ Other: ____

I, hereby certify that my answers to the foregoing questions are correct and true, to the best of my knowledge and belief.

Signature & Stamp of the Attending Physician: ____

Name & Address: ____

Phone Number: ____ Fax # ____

Credentials/Qualifications: ____ Date: ____