CIC GENERAL INSURANCE LTD

OUT PATIENT CLAIM FORM

CIC GROUP

PATIENT'S INFORMATION

Scheme Name: _____ Employee's Name: _____

Patient's Name: _____ Date of Birth: _____

Membership No: _____ National ID (must provide): _____

Patient mobile number: _____ Email: _____

Relationship of patient to Employee: (Tick against the box): Self: ☐ Spouse: ☐ Child: ☐

SERVICE PROVIDER DETAILS

Name of Clinic: _____

Consulting Physician: _____ Treatment Date: _____

MEDICAL INFORMATION

Presenting complaints: _____

Is the condition: Acute: ☐ Congenital: ☐ Chronic/Recurring: ☐

Date the illness was first diagnosed: _____

Diagnostic & laboratory Findings: _____

Provisional/Final diagnosis: _____

Cause of the illness: _____

Plan of Management: _____

PROVIDER'S DECLARATION

I certify that the above patient has received the services & treatment noted on this form, diagnosed and administered by myself and that this claim is in accordance with my specified treatment.

Doctor's Name: _____

Signature: _____ Date: _____

DATA PROTECTION AND PRIVACY

CIC General Insurance Limited is committed to complying with the requirements of the Data Protection Act and the attendant regulations as well as global best practices regarding the processing of your personal data. In this regard, you are required to acquaint yourselves with our data privacy statement *(https://cic.co.ke/data-privacy-statement/)* which is intended to inform you on how we use your personal data and describes how we collect and process your personal data during and after your relationship with us.

MEMBERS CONSENT AND DECLARATION

I hereby acknowledge that my signature below constitutes my express, reasonable, unconditional, specific and voluntary consent to the collection, use and processing of my personal and/or sensitive personal information. I further acknowledge that I have read and understood CIC Group's Data Privacy Statement and agree that this declaration shall be held to be promissory.

I warrant that the answers in this form and all documents submitted are true, correct and complete. CIC General Insurance Limited therefore holds no liability for any inaccurate information provided herein.

I hereby authorize the provider of the service(s) who have treated me or any of my dependents to disclose to the company the records relating to such current or previous hospitalizations/medical treatment and to allow the company to receive extracts from such records and undertake to assist in obtaining such information for processing where applicable.

Patient/Parent/Guardian's name: _____

Signature: _____ Date: _____

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