THE KENYA BANKERS
BANKING KENYANS

# IN-PATIENT HOSPITALIZATION, RISK MANAGEMENT FUND CLAIM FORM

SECTION A : ( TO BE COMPLETED BY THE MEMBER ( PATIENT ) OR BY HIS / HER AGENT IN CASE HE / SHE IS UNABLE DUE TO ILLNESS )

FULL NAME : ----------

ID NO. ----------

EMPLOYER DETAILS ----------

BRANCH ---------- TEL NO. ----------

DATE OF ADMISSION TO HOSPITAL ----------

DATE OF DISCHARGE FROM HOSPITAL ----------

NAME OF HOSPITAL ----------

**I CERTIFY THAT THE INFORMATION GIVEN IS ACCURATE TO THE BEST OF MY KNOWLEDGE**

SIGNATURE OF MEMBER / AGENT ----------

MEMBERSHIP NO. ---------- DATE ----------

NAME OF WITNESS ---------- ID NO. ----------

SIGNATURE OF WITNESS ---------- MEMBERSHIP NO. ----------

**SECTION B : DOCTORS COMMENTS IN - CASE THE MEMBER ( PATIENT ) IS NOT ABLE TO SIGN**

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**OFFICIAL RUBBER STAMP**

DOCTORS SIGNATURE ---------- DATE ----------

NOTE : ( This claim form duly completed to be forwarded to the manager together with the hospital's invoice or interim statement )

SECTION C : (FOR OFFICIAL USE ONLY )

MANAGERS COMMENT ----------

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THE KENYA BANKERS CENTRE, 3RD NGONG AVENUE, UPPER HILL
P.O. Box 73236 - 00200 City Square, Nairobi.
Tel: +254 20 5146500, Email: help@kenyabankers.coop

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## SECTION D

## BOARD OF TRUSTEES

We have today ---------- ( Date ) considred this claim in conjunction with the above comments and have approved the claim. Authority is hereby granted to the Manager to draw a cheque for KES ---------- ---------- payable to ----------( Name of Hospital )

SIGNED ---------- DATE ----------

( CHAIRMAN )

SIGNED ---------- DATE ----------

( SECRETARY )

SIGNED ---------- DATE ----------

( MEMBER )

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