# Jiban bima corporation

**(Only state owned life insurance company of Bangladesh)**
**Head office: 24, Motijhel C/A Dhaka-1000**
**Telephone: 02-223385720, PBAX: 02-223381423 Fax: 02-223381825**
**Post box no-345,625, G.P.O. Fhaka, E-mail:info@jbc.gov.bd, website: www.jbc.gov.bd**

## (HEALTH INSURANCE CLAIM FORM)

N.B : Please note that reimbursement of claim can only be made when all original documents and bills are submitted together with this form as mentioned below. ALL CLAIMS SHOULD BE SUBMITTED THROUGH THIS FORM.

| | | |
|---|---|---|
| 1. Name of Organization: | ☐ Breakup of Hospitalization Treatment Expenses : | Amount (Taka) |
| 2. Name of Employee: | | |
| 3. Designation: | Maximum benefit per insured per year | Tk:1,00,000/- |
| 4. Branch/Sales/Region/Corporation/Division/Department: | Maximum number of days of hospital stay in a year | 20 days |
| | Room Rent (actual including daily max.) | Tk:2,000/- |
| 5. Name of Patient: | Maximum days of stay per admission (Days) | 12 days |
| 6. Relationship with Employee ( if the patient is spouse/dependent): Husband Wife Son Daughter Self | Consultation fee (Actual fee per visit and up to one visit per day) Tk 500 per visit Maximum 20 (twenty) days (in one admissionthe highest 12 days) | Tk:10,000/- |
| 7. Employee ID | Medicines and accessories – Actual or maximum cost in a year | Tk:8,000/- |
| 8.Cell no. | Investigations (pathological examination and x-rays-every year) are max | Tk:5,000/- |
| 9. Date of Prior Intimation : | Operation-OT charges, CABG,PCI/stent, press maker charges,Cataract operation, any kind of operation,Surgeon and Assistant Surgeon Charges, including anaesthesia and medical board max | Tk:20,000/- |
| 10. Membership No : | Ancillary Services (Oxygen Therapy, Chemotherapy, Radiation Therapy, Immune therapy, Stem Cell Therapy, Iodine Therapy, Incubator, Ventilator, Blood Transfusion, Ambulance Service, Intensive Care Unit, Critical Care Unit, Dressing, Post Operative Care, Kidney Dialysis etc.) per member per year | |
| 11. Name and Address of Hospital/Clinic : | | |
| 12. Date of Admission: | Stent (if required) Maximum benefit per insured per year | Tk:17,000/- |
| 13. Date of Discharge : | Total | Tk:1,00,000/- |
| 14. **Signature of the Employee/claimant & Date:** | **Signature of the Department/Regional/Corporate/Sales head & Date:** | |

**(To be filled in by the Plan Coordinator/ Department/Regional/Corporate/Sales in charge of Jiban Bima Corporation)**
**Documents required during submission of claim for reimbursement:**
**Please tick the appropriate boxes for the submitted documents:**

- ☐ **Claim form dully filled in by employee concerned**
- ☐ **Copy of Prior Claim Intimation Record. OR date of telephonic intimation___/_____/_____**
- ☐ **Doctor's prescription(s) mentioning-duration of presenting complaints, diagnosis and hospitalization advice in original.**
- ☐ **Discharge Certificate stating brief history of illness, diagnosis & treatment/operation note and also mentioning time & date of admission and discharge.**
- ☐ **Certificate from Employer/Educational institution in regard to absence during illness.**
- ☐ **Photocopy of patient's Treatment Records while confined in hospital/clinic**
- ☐ **Hospital Bill should be supported by original Money Receipt issued by the hospital.**
- ☐ **All copies of diagnostic reports pertaining to the hospitalization along with the receipts in original supported by Doctor's advice.**

**Original Bills specifying:**

- □ **Accommodation Charges (mentioning daily charge with number of days in hospital).**
- □ **Consultant's Fee (Doctor's bill & receipts with date).**
- □ **Medicines/Drugs (Bill stating name of medicine, quantity & price supported by Doctor's prescription).**
- □ **Surgical Charges (A break-up of professional fees for Surgeon, O.T., Anesthetist, Assistants etc.).**
- □ **Changes for accessories supplied for hospital/clinic (with name, Quantity and price)**
- □ **Charges for Ancillary Services (Labor Room Service, Post-Operative Care facilities, Oxygen therapy, Intensive Care facility, Blood transfusions, Equipment charges, dressing, tests other than routine investigations, Ambulance services etc.).**
- □ **Service charge, telephone, food & beverage charges.**
- □ **Any other bill (orginal)**

**Forwarded the above mentioned information to JBC with the necessary supporting documents for processing of the claim as per Contract**

**Ref No.** **Date:** **Signature of Plan Coordinator with Seal**

**For Official use by employer**

| **Name of the employee** | **ID No:** | **Claim amount Tk:** |
|---|---|---|
| | | |

**Necessary supporting documents** **Complete** ☐ **Needs to be verified by JBC** ☐

**Ref No:** **Date:** / /

To
Group Insurance Division
Jiban bima corporation
24/ Motijhel C/A
Dhaka

Sending herewith the claim form duly filled in by the employee along with the necessary supporting documents for reimbursement of this claims at your earliest.

_____

Authorizes Signature Official Seal

For official use by JBC(Group Division)

**Date of receipt:** / /

**Claim no**

**Date of intimation** / / **(If submitted documents, bills & vouchers are incomplete)**

**Date of receipt of complete claim** / /

**Amount of reimbursement**

**Date of reimbursement** / /

**Remarks:**

_____

**Signature**
**(Authorized Officer)** **Date:**