MEDICAL EXPENSES REIMBURSEMENT CLAIM FORM

Capital Insurance Limited
P.O Box 14468
Suva, Fiji
www.cig.com.pg

INSURED'S DETAILS:

Insured Name:	
Postal Address:	
Email Address:	
TIN/FNPF/EDP/Employee No:	
Phone Contact:	
Name of Patient:	
Relationship to the Insured:	
Name of Physician:	
Date Treated:	
Diagnosis	

COST INCURRED	**CURRENCY (FJD)**
Overseas claim	$
Doctor's Fee	$
Pharmacy Bill	$
X-Ray and Lab Charges	$
Specialist Fees	$
Dental	$
Optical	$
Maternity	$
TOTAL CLAIMED AMOUNT	$

IMPORTANT CHECKLIST

(i)	Attach all relevant Medical Reports in respect to this claim	Yes	No
(ii)	Are All Original Receipts Attached	Yes	No
(iii)	X-Ray & Lab Charges – Please Attach Referral Letter from your Doctor	Yes	No
(iv)	Specials Referral – Please Attach Referral Letter from Your Doctor	Yes	No
(v)	Optical/Dental – Please Attach Optician/Dental Report	Yes	No

BANK ACCOUNT DETAILS

All claims payment will be credited directly to your bank account Bank name (eg. ANZ, WBC, BSP,HFC, Bred Bank and Bank Of Baroda:

BRANCH:	
BANK ACCOUNT HOLDER'S NAME:	
BANK ACCOUNT NUMBER:	

SIGNED: ..... DATE:.....

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