Al Ahleia Insurance S.A.K.P.
Ahmad Al-Jaber Street
P.O. Box: 1602 Safat 13017 Kuwait
Tel: +(965) 1888 444
Fax: +(965) 22 411 330
Authorized K.D. 30,000,000
Issued & Paid Up Capital K.D. 23,600,000
Registered In Accordance with the Insurance Companies
and Agents, Law No. 125 for 2019 & Attachments
Insurance License No. IRC20200003 Commercial Reg. No.9389

الأهلية للتأمين
AL AHLEIA INSURANCE

الشركة الأهلية للتأمين ش.م.ك.ع.
شارع أحمد الجابر
ص.ب: 1602 الصفاة 13017 الكويت
تلفون: 444 1888 (965)+
فاكس: 330 411 22 (965)+
رأس المال المصرح به 30,000,000 دينار كويتي
المصدر والمدفوع 23,600,000 دينار كويتي
شركة خاضعة لأحكام قانون شركات
ووكلاء التأمين رقم 125 لسنة 2019 وملحقاته
رقم الإجازة IRC20200003 سجل تجاري 9389

Patient Information:

Policyholder Name: ____________________

Policy Number: ____________________

Member Name: ____________________

Member Number: ____________________

Civil ID Number: ____________________

Insured Mobile Number: ____________________

Expenses & Billing Details:

Description	Amount
Consultation Fees:	____________________
Hospitalization Costs:	____________________
Medication Costs:	____________________
Lab Tests & Imaging Cost:	____________________
Procedures Costs:	____________________
Total Claimed Amount:	____________________

Provider Information:

Doctor/Dentist Name: ____________________

Hospital/ Clinic Name: ____________________

Treatment Type:

☐ Inpatient ☐ Outpatient ☐ Dental ☐ Pregnancy/Maternity

Diagnosis & Treatment Details:

Date of treatment: ____________________

Complaints: ____________________

Procedures Performed: ____________________

(in case of dental please specify the tooth no.)

Medication Prescribed: ____________________

Test Results (if applicable): ____________________

Final Diagnosis: ____________________

(in case of pregnancy please specify duration of pregnancy in weeks)

Supporting Documents Checklist:

☐ Detailed Medical Reports
☐ Hospital/Clinic original invoices
☐ Prescription Copies
☐ Test/Lab Reports
☐ Discharge Summary (for inpatient)
☐ Dental Treatment Details & original Invoice
☐ Pregnancy-related Documents (Ultrasound, Doctor's Notes)
☐ Civil ID & Med. Insurance Card

Declaration & Signature:

"I hereby declare that the information provided is true and complete to the best of my knowledge."

Patient's Signature: ____________________ Date: ____________________

Doctor's Signature & Stamp: ____________________ Date: ____________________