Jubilee
HEALTH INSURANCE

MEDICAL INSURANCE
PROVIDER APPLICATION FORM

JUBILEE HEALTH INSURANCE LIMITED

Head Office:
Jubilee Insurance Centre, Kilimanjaro Avenue,
P.O. Box 6694 - 00100 GPO, Nairobi, Kenya
Tel: +254 20 328 1000
Call Centre: +254 709 949 000
Email: talk2ushealth@jubileekenya.com
www.jubileeinsurance.com

DIRECTIONS:

All questions must be filled in full block letters.

The dully filled application form and a comprehensive facility profile should be sent to the email address ***medicalproviders@jubileekenya.com.***

Section 1:

Personal Information and Professional Documents

Attach the Certificate of Incorporation and Registration/Change of Name Certificate

Provider Type: Hospital: ☐ Health care facility: ☐ Specialist Clinic: ☐ Pharmacy: ☐ Optician: ☐ Other:

Provider Name: _____

Have you ever used another name in the past ? ☐ Yes ☐ No

If yes, kindly list all other names used and the period of use below

Period of use: _____ Reason for Change: _____

Address and location

Attach list in case of multiple locations

Registered office: _____

Town: _____ County: _____ Address: _____

Postal code: _____ Office telephone: _____

Mobile No: _____ E-mail address: _____

Account details

Ensure the information provided is accurate since this will be the transaction details

Attach a copy of PIN, ID NO/Certificate of Incorporation and NHIF Certificate

Bank Name: _____ Branch: _____

Branch No: _____ Account Number: _____ Swift Code: _____

Account Name: _____ PIN NO: _____

ID NO: _____ NHIF No: _____

Professional Documents

Attach copies of the Company Profile (details of the facility ownership and branches), licenses & certificates

Business Registration number: Date Issued:

Expiry Date:

Pharmacy and Poisons Board License No: Date Issued:

Expiry Date:

Private Practice License No: Date Issued:

Expiry Date:

Kenya Medical Practitioners and Dentists Board

Date Issued: Expiry Date:

Section 2:

Medical Practice Information

Primary Specialty Group

Attach copies of the evidence where applicable

Type of Practice: ☐ Solo Practice: ☐ Single Specialty Group: ☐ Multi-Specialty Group:

(Select only one)

What is your Primary area of specialty?

State other sub-specialty:

Services

Attach copies where applicable

Do you provide any of the following services ?

Laboratory: ☐ Yes ☐ No

If yes provide Accrediting/Certifying body:

Radiology ☐ Yes ☐ No

If yes provide Accrediting/Certifying body:

Pharmacy ☐ Yes ☐ No

If yes provide Accrediting/Certifying body:

Ambulance ☐ Yes ☐ No

If yes provide Accrediting/Certifying body:

Other Services:

Attach the services price list and CVs of the supervising staff for every section of your business

No of Staff: Are you accredited by the NHIF ? ☐ Yes ☐ No

If yes, provide your Rebates amounts:

Attach the NHIF Accreditation report

Working arrangements

Attach copies of the evidence where applicable

Do you have working arrangements with other providers ?

1.Name: Nature of Business:

State the Relationship:

2. Name: Nature of Business:

State the Relationship:

If you have more working arrangements kindly state in a separate page.

Admitting Rights

Attach copies of the evidence where applicable

Do you have Admission Rights with any Facilities ☐ Yes ☐ No

Name of the Facility	Location of the Facility

If you have more Admission Rights kindly state in a separate page.

Section 3:

Insurance Cover

Professional Indemnity/Medical Malpractice Insurance Cover

Attach the cover details

Do you have PI cover for your institution staff/self ? ☐ Yes ☐ No

If yes, who is the insurer ?

Policy Effective Date: Policy Expiry Date:

Section 4:

Work History and References

Attach copies of the evidence where applicable

Are you a provider with any other Insurance firm ? ☐ Yes ☐ No

If yes, kindly state which Insurance firm you are currently working with:

1. Name of Insurer: Duration:

2. Name of Insurer: Duration:

If you have more working arrangements kindly state in a separate page

References

Provide two professional references who are not partners in your practice

1. Name:

Address: Postal Code: Town:

Country: | Email Address: | Telephone Numbers:

2. Name:

Address: | Postal Code: | Town:

Country: | Email Address: | Telephone Numbers:

Section 5:

Disclosure Clause

To be signed by two directors if it's an entity & one signature for a practicing professional

Have you ever been charged or associated with any form of medical negligence? ☐ Yes ☐ No

Have you ever been associated with any illegal activities, fraud or any terrorism related activities? ☐ Yes ☐ No

If yes, please provide more details and attach any related documents

Name: | Signature | Date

Name: | Signature | Date

Name: | Signature | Date

Name: | Signature | Date

Section 6:

DECLARATION CLAUSE:

I/We the Undersigned Members

i. Hereby apply for myself/my entity to be registered on Jubilee Health Insurance provider panel.

ii. Warrant that the contents of this application and any other documents which may be required in support thereof are true,correct and complete, should there be any change from the date of signing this application form and the date ofaccreditation by Jubilee Health Insurance, notification of such change will be provided to Jubilee Health Insurance in writingwith full details of the changes.

iii. Understand that the statement and answers provided form the basis of the contracts Jubilee Health Insurance shall enter withme/us and any breach of my warranty or non-disclosure of any information material to the assessment of this applicationshall render any contracts to which this application relates null and void.

iv. Undertake to inform Jubilee Health Insurance within 30 days should the situation stated above change.

Signature & Stamp of Member/Institution: | Date:

Name of Authorized Signatory: | Date:

FOR OFFICIAL USE ONLY:

1. Provider Audited: ☐ Yes ☐ No

2. Provider Application: ☐ Accepted ☐ Declined

3. Vetting Officers:

Name: | Designation | Date

Name: | Designation | Date

Name: | Designation | Date

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CONTACT US

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