**JUBILEE HEALTH INSURANCE LTD – CUSTOMER COMPLAINT FORM**

This form is for use by members of Jubilee Health Insurance Limited.

At Jubilee Health Insurance, we are committed to ensuring that all our members receive quality healthcare services. If you have experienced a challenge or dissatisfaction at any of our accredited health service providers, please fill out this form to help us resolve the matter promptly.

**Section 1: Member Details**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Membership Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Contact Method: ☐ Phone ☐ Email

**Section 2: Health Service Provider Details.**

Name of Facility/Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location of Facility (City/Branch): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Visit/Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name(s) of Attending Staff/Doctor (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 3: Nature of Complaint**

☐ Delayed Service/Long Wait Time  
☐ Unprofessional Staff Conduct  
☐ Denial of Service  
☐ Overcharging/Billing Issue  
☐ Unauthorized Co-payment or Preauthorization Request  
☐ Poor Quality of Care  
☐ Communication Breakdown  
☐ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 4: Description of Complaint**

Please describe what happened. Include as much detail as possible such as times, names, and any relevant circumstances.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 5: Supporting Documents**

Please list any attached files such as receipts, reports, or photos submitted with this form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 6: Desired Resolution/Feedback Sought**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 7: Declaration**

I declare that the information provided in this form is true and complete to the best of my knowledge. I consent to Jubilee Health Insurance sharing this complaint with the relevant healthcare provider for investigation and resolution.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 8;** **Data Consent**

By completing and submitting this form, you consent to the collection, processing, and secure storage of your personal data by Jubilee Health Insurance Limited for the purposes outlined in this document.

Your information will be used solely for its intended purpose and will be handled in accordance with applicable data protection laws and our privacy policy. You have the right to access, correct, or request the deletion of your data at any time. To exercise these rights or for more information, please contact us at **Call**: 0709 949 000, **Email**: [health@jubileekenya.com](mailto:health@jubileekenya.com).