



NATIONAL HOSPITAL INSURANCE FUND

P.O. Box 30443, NAIROBI

Website: www.nhif.or.ke Email: info@nhif.or.ke

**APPLICATION FOR PERMISSION TO CLAIM BENEFITS
FOR TREATMENT RECEIVED OUTSIDE KENYA**

Member's Number

1. Name of the contributor (in full)

2. Postal Address of the contributor

3. Name of the Contributor's Employer

4. Name of the patient

5. Date of birth of

6. Relationship of patient to contributor

(State whether contributor, wife, husband or child)

7. Nature of Treatment

8. Reason why treatment was not obtained in Kenya

9. Period of In-patient

From (Inclusive)

10. Name of Hospital

(Statement of admission and discharge and receipts for payments must be sent in support)

11. I certify that my contribution to the National Hospital Insurance Fund have been paid to date and attach my | contribution card in evidence.

If this application is approved please pay

..... (Name Branch of Bank)

Date (Signature) _____

FOR OFFICIAL USE

Approved/*Rejected by _____

For reasons, see the attached letter.