GIG Medical Insurance Scheme
Chronic Medical Form

Part 1

Policy No.: ______________________ Policy Holder: ______________________

To be completed by Employee/Patient

* Patient Name: ______________________ * CID: ______________________

Member's Signature: ______________________ Date: ______________________

Part 2

To be completed by Doctor/Specialist who carried out the treatment

* **Diagnosis:** 1. ______________________

2. ______________________

3. ______________________

4. ______________________

* Name of medicine	* Dose

Doctor/Specialist's Signature & Stamp: ______________________ **Date** ______________________

N.B: All fields with (*) mandatory to be filled

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