KENINDIA ASSURANCE COMPANY LIMITED

(Incorporated in Kenya)

P.O. Box
NAIROBI Kenya
Tel:
Cable: KENINDIA KE.

MEDICAL INSURANCE CLAIM FORM

This form should be completed in block letters, signed by the Member and the Medical Advisor on whose recomendation the treatment was undertaken and returned to us with all relative accounts.

In your own interest, full information should be given.

All information supplied will be treated in strict confidence.

No admission of Liability is made by Underwriters by the issue of this form.

1. NAME OF YOUR EMPLOYER _____
   (Group Schemes Only)
2. MEMBER'S NAME _____
3. ADDRESS _____
4. PATIENT'S NAME _____ AGE _____
5. NATURE OR CONDITION WHICH NECESSITATED TREATMENT (IN BLOCK LETTERS)

   _____
6. DATE WHEN PATIENT FIRST MEDICALLY EXAMINED FOR CONDITION _____
7. HAVE YOU SUFFERED FROM THIS COMPLAINT PREVIOUSLY. IF SO, WHEN _____
8. NATURE OF TREATMENT (IN BLOCK LETTERS) _____

   _____
9. NAME AND ADDRESS OF MEDICAL ADVISOR _____

   _____

   _____

   _____

Continued Overleaf:-

N.B. RECEIPTED ACCOUNTS OR VOUCHERS SUPPORTING THESE EXPENSES MUST BE ATTACHED

DETAILS OF EXPENSES	Shillings	Cents
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
TOTAL		

The above mentioned Patient has undertaken the treatment specified on my recommendations:

*Signature of Medical Adviser _____

*Date _____

I hereby declare that all the statements given by me on this form are to the best of my knowledge true and complete.

Signature of Member _____

Date _____

FOR OFFICE USE ONLY:-

TOTAL CLAIM SHS. _____

SETTLEMENT SHS. _____

DETAILS OF PREVIOUS CLAIMS

CLAIM NO.	AMOUNT	DATE