



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 recommendation 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 Advisor _____

*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.
1000000	1000000
2000000	2000000
3000000	3000000
4000000	4000000
5000000	5000000
6000000	6000000
7000000	7000000
8000000	8000000
9000000	9000000
10000000	10000000
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94000000	94000000
95000000	95000000
96000000	96000000
97000000	97000000
98000000	98000000
99000000	99000000
100000000	100000000

SETTLEMENT SHS.

DETAILS OF PREVIOUS CLAIMS

CLAIM NO. -	AMOUNT	DATE