General Accident

GENERAL ACCIDENT INSURANCE COMPANY KENYA LIMITED

Incorporated in Kenya

4th Floor General Accident House, Ralph Bunche Road, P.O. Box 42166, 00100 - Nairobi, Kenya
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MEDICAL INSURANCE CLAIM FORM

IMPORTANT — PLEASE NOTE:—

ALL INFORMATION PROVIDED WILL BE TREATED IN STRICT CONFIDENCE.
TO AVOID DELAY AND UNNECESSARY CORRESPONDENCE IN THE SETTLEMENT OF A CLAIM PLEASE OBSERVE THE FOLLOWING REQUIREMENTS:—

1. COMPLETE A SEPARATE CLAIM FORM FOR EACH INSURED PERSON.
2. COMPLETE A SEPARATE CLAIM FORM FOR EACH ILLNESS/ACCIDENT.
3. YOU MUST QUOTE YOUR CERTIFICATE NUMBER.
4. ANSWER EACH QUESTION OF THE SECTION IN WHICH MEDICAL EXPENSES HAVE BEEN INCURRED.
5. RECEIPTED DETAILED ACCOUNTS MUST BE SUBMITTED WITH THE CLAIM FORM.
6. COPY PRESCRIPTION NOTE MUST ACCOMPANY EACH CHEMIST'S CASH SALE.
7. DOCTORS ACCOUNTS SHOULD STATE DATES OF TREATMENT AND CHARGES.

NO CLAIMS WILL BE CONSIDERED WITHOUT ABOVE DETAILS

1. Name of Insured/Scheme .....
2. Policy No. ..... Name of Insured Member .....
3. Certificate No. ..... Plan ..... Address .....
4. Name of Insured Person for whom claim is made .....
5. Family No. of Insured Person .....
6. If claim is for Accident, state Date of Accident, Nature of Accident and Nature of Injury.....
   .....
7. If claim is for illness, state Nature of Illness (BLOCK LETTERS) .....
   .....
8. Have you suffered previously from this type of illness and/or Injury? .....
9. If so, please state when. .....
10. When did the current illness first occur? .....
11. Are you a member of the NATIONAL HOSPITAL INSURANCE FUND?.....
12. Are you insured under any other Medical Expenses Scheme, Workmen's Compensation, Personal Accident or other Policies from which the whole or part of the Medical Expenses now being claimed can be recovered? If so, give particulars, i.e. name of Insurers, Policy No., etc. .....
    .....
    .....

I hereby declare the above answers to the questions are correct, complete and true. I confirm that I had no knowledge that the treatment in respect of which this claim is made would be necessary prior to joining the Scheme. I agree that the Insured Person will attend a medical examination if required. I further agree that the Company may obtain medical information from any Medical Practitioner or Hospital for past treatment. I enclose all accounts to substantiate this claim.

Date ..... Signature of Member .....

PLEASE GIVE DETAILS OF CLAIM OVERLEAF

MEDICAL EXPENSES SECTION

1. **DOCTOR**
   - Doctor consulted. .....
   - Address. .....
   - Date of First Consultation .....
   - Consultation fee per visit Shs. .....
   - TOTAL FEES PAID Shs. .....

2. **PRESCRIBED MEDICINE**
   - Chemist Supplying Medicine .....
   - Address .....
   - TOTAL COST PAID Shs. .....

3. **CONSULTANT, SPECIALIST, PATHOLOGIST OR SURGEON**
   - Specialist Doctor .....
   - Address .....
   - TOTAL FEE PAID Shs. .....

4. **SURGEONS, ANAESTHETISTS AND OPERATING THEATRE**
   - Surgeon Doctor .....
   - Address .....
   - TOTAL FEES PAID Shs. .....

5. **X-RAYS AND PHYSIOTHERAPY TREATMENT**
   - Doctor Recommending .....
   - Address .....
   - Details of Treatment .....
   - .....
   - TOTAL FEE PAID Shs. .....

6. **SURGICAL APPLIANCES**
   - Doctor Recommending .....
   - Address .....
   - Details of Appliances .....
   - TOTAL COST PAID Shs. .....

7. **AMBULANCE EMERGENCY TRANSPORT**
   - Nature of Injury or Illness .....
   - Emergency Transport by .....
   - Time and Date of Transportation .....
   - TOTAL CHARGES PAID Shs. .....

(RECEIPTED DETAILED ACCOUNT TO BE ATTACHED)

HOSPITALISATION SECTION

HOSPITAL OR NURSING CHARGES
- Institution entered .....
- Date of Entry ..... Date of Discharge .....
- Room and Board Daily charges .....
- If At Home
- Name of Nurse and Qualification .....
- Private or Institutional .....
- Period from ..... to .....
- Nursing Daily Charges .....
- TOTAL FEES PAID Shs. .....
- (Detailed Accounts Attached)