GEMINIA INSURANCE COMPANY LIMITED
Head office: Le'Mac, 5th Floor
P.O. Box 61316-00200, Nairobi
Tel: 2782000 Fax: 2782100
Email: info@geminia.co.ke
www.geminia.co.ke

MEDICAL CERTIFICATE

INSTRUCTIONS:
This form should be completed by the Doctor and sent to the Company on the above address under Registered Cover. Any delay in sending this form may prejudice the claimant. X-Ray or any relevant reports should accompany this form so that the Company's Medical Officer may understand the exact nature and extent of the injuries or illness.

Part 1: CLAIMANT DETAILS

Claimant's name_____

For what previous illness or injuries have attended the claimant?_____

Part 2: INJURY DETAILS

Claimant's Age_____years. Weight_____lbs. Height_____Feet_____inches

Description of present injuries, if to an aye, hand or an arm, foot or leg, state whether it is the right or left

_____

_____

Are the injuries in their present condition sufficiently accounted for by the description of the accident given by the Claimant? Yes ☐ No ☐

Date injuries sustained_____

On what day and where did you first attend the Claimant in consequence of such injuries?_____

Are you aware of anything in the previous medical history of the Claimant which might have contributed, directly or indirectly to the occurrence of the accident, or which may be likely in any way to retard his recovery from it ? Yes ☐ No ☐

Other relevant comments:_____

_____

Please state duration of TOTAL disablement days PARTIAL disablement days_____

Note: By Total Disablement it is understood that the claimant is prevented by the injury from attending any portion of business or occupation. Partial Disablement is when the Claimant is so slightly injured, or has so far recovered, as to be able to transact some portion of business or occupation, but not the whole.
I certify to the Directors of the GEMINIA INSURANCE CO. LTD, that the foregoing statements are correct, and that i have no reason to suspect the Claimant was otherwise than sober when the accident occurred.

Signature:_____Qualification:_____

Telephone No:_____Date:_____Address:_____

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