GEMINIA INSURANCE COMPANY LIMITED
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GEMINIA INSURANCE CO.LTD.

MEDICAL INSURANCE
CLAIM FORM

INSTRUCTIONS:

- Please read carefully and fill out the entire document.
- All questions must be answered in full, in BLOCK letters in the applicants own handwriting or dictation.

Name of your Employer _____

Member's Name _____

Address _____

Patient's Name _____

Nature or condition which necessitated treatment(in BLOCK letters) _____

_____

Date when patient first medically examined for condition _____

Have you suffered from this complaint previously, if so when _____

	DETAILS OF EXPENSES	Shs	Cts

Name and Address of Medical Adviser _____

The above mentioned Patient has undertaken the treatment specified in 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. I authorize the Company if it deems it necessary to contact the Medical Adviser/Hospital/Pharmacy/Dispensary to obtain clarification or information pertaining to this claim.

Signature of Member _____ Date _____