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 INSURANCECLAIM 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		
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 to the Company if it deems it necessary to contact the Medical Adviser/Hospital/Pharmacy/Dispensinformation pertaining to this claim.	— rue and complete. I a ary to obtain clarificat	uthorize tion or
Signature of Member Date		