OCCIDENTAL INSURANCE COMPANY LIMITED
Crescent Business Centre, 7th Floor, Parklands Road, Parklands,
P.O. Box 39459-00623, Nairobi, Kenya,
Tel: 0709-896000, 020-2362602, 0734-600485
E-Mail: enquiries@occidental-ins.com
Website:www.occidental-ins.com

MEDICAL INSURANCE CLAIM FORM

This form should be completed in block letters, signed by the Member and the Medical Adviser 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 NECESSITIATED TREATMENT (IN BLOCK LETTERS)
_____

6. DATE WHEN PATIENT FIRST MEDICALLY EXAMINED FOR CONDITION
_____

7. HAVE YOU PREVIOUSLY SUFFERED FROM THIS COMPLAINT. IF SO, WHEN
_____

8. NATURE OF TREATMENT (IN BLOCK LETTERS)
_____

9. NAME AND ADDRESS OF MEDICAL ADVISER _____
_____
_____
_____
_____

Continued Overleaf:

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 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.

Signature of Member _____

Date _____

FOR OFFICE USE ONLY:-

TOTAL CLAIM SHS.

SETTLEMENT SHS. _____

DETAILS OF PREVIOUS CLAIMS

CLAIM NO.	AMOUNT	DATE

N.B. RECEIPTED ACCOUNTS OR VOUCHERS SUPPORTING THESE EXPENSES MUST BE ATTACHED