CLARKSON NOTCUTT (INSURANCE BROKER) LTD

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MEDICAL EXPENSES INSURANCE CLAIM FORM

NB. YOUR CLAIM WILL NOT BE CONSIDERED UNLESS YOU COMPLY WITH THE FOLLOWING:-

1. Complete a seperate claim form for each insured person and for each illness.
2. The Certificate detailed overleaf MUST be signed by your MEDICAL ATTENDANT.
3. The ORIGINAL DETAILED ACCOUNTS MUST be attached to this form.
4. Answer all questions below - dashes are not acceptable.

QUESTIONS.

1. NAME OF EMPLOYER..
2. NAME OF EMPLOYEE..STAFF NO ....
   DEPARTMENT................................
3. ADDRESS..
4. PATIENT'S NAME...AGE..............................

5. SICKNESS
   (a) (To be answered by the consulting Doctor)
   Nature of sickness..
   (b) With regard to expenses being claimed now, when did sickness start?...
   ....
   (c) When did you / patient consult the doctor with regard to this claim?
   and how frequent is it?..
   (d) (To be answered by the consulting Doctor)
   In your opinion is this illness chronic or recurring?..
   ....
   Give comments if any...
   (e) If claim is related to accident, please give brief particulars...
   ....
   (f) (To be completed by the consulting Doctor)
   Nature of treatment..
6. GENERAL:-
   (a) Do you have any other insurance policy e.g. NHIF under which these expenses can be claimed wholly or partially?.. if so give details...
   ....
   (b) Did your doctor refer you to a specialist?...
   If yes, are specialists bills attached?...

DECLARATION
I on my Behalf/patient warrant the truth of the above statements. I have not witheld or mistated material information relating to this claim and have no objection to insurers or their representatives communicating with my medical Doctor (s) regard to this claim.

Date... Signature...

DETAILS OF MEDICAL EXPENSES.

N.B. ATTACH ORIGINAL RECEIPTED ACCOUNTS OR VOUCHERS.
N.B. EXPENSES OVER 60 DAYS ARE TIME-BARRED AND SHOULD NOT BE INCLUDED.

ITEM	DESCRIPTION	AMOUNT
1. (a)	Consulting Doctor's Fees( )Visits @	
(b)	Specialist Fee	
2.	Prescribed Drugs	
3.	Hospital Bills	
4.	Lab Tests	
5.	X-Rays	
6.		
7.		
8.		
9.		
	TOTAL	

CERTIFICATE OF MEDICAL PRACTITIONER

I certify that to the best of my knowledge and belief the statements made overleaf relating to the illness / injury of the insured person for whom this claim is made are true. I have treated this patient and the medical expenses detailed above were necessarily incured as a direct result of this illness / injury reffered to.

Doctor's Name...

Doctor's Signature...

Date:...

RUBBER STAMP