



ACROPOLIS INSURANCE BROKERS LTD.

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MEDICAL CLAIM FORM.

All questions must be answered in full, in BLOCK letters, in your own handwriting or to your dictation.

Name of Hospital / Provider

Telephone & Fax Nos.

Policy / Membership No.

Employee Name

Employee No. (if available)

Patient Name

Date of Birth / Age

Relationship to Employer

I.D. No.

I, _____ do hereby authorize any doctor, hospital, clinic or medical provider, any other company, institution or person(s) who has a record or information about me and / or my family members to provide my insurer with a complete information including copies of their records with reference to my illness or accident, any treatment, examination, advice or hospitalization. I have also been advised by the insurer and have understood the various exclusions. Any photocopy of this authorization shall be taken as the original copy.

Signature of Member:

Date:

TO BE COMPLETED BY THE DOCTOR

Final diagnosis of illness treated.

When the condition was first diagnosed?

Cause of illness(es)

Is the condition a General Exclusion? Yes No

Nature of treatment and given recommendations

ACCIDENTS

Date of Accident

Cause of Accident

Nature of Injuries.

Private Doctors Fees: Kenya Shillings (KES)

Prescribed Drugs:

Specialists and Pathologists Fees:

X-Ray & Physiotherapy Fees:

TOTAL CLAIM:

I hereby confirm that the above information provided is true and correct to the best of my knowledge.

Date _____

Doctor's Signature
and Stamp _____