ACROPOLIS INSURANCE BROKERS LTD.
3rd Floor, Eldama Flats, Eldama Ravine Road/Ngao Road, Parklands.
P.O. Box 1157, Sarit Centre Post Office, Nairobi 00606, Kenya.
Telephones +254 771 444746 / 771 444747 / 770 298820. Fax (020) - 2349284.
Email info@acropolisinsurance.com

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.	

Kenya Shillings (KES) Private Doctors Fees: 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 _____