



THE HERITAGE INSURANCE COMPANY LIMITED

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MEDICAL EXPENSES INSURANCE CLAIM FORM

I. TO BE COMPLETED BY THE CLAIMANT

NB: YOUR CLAIM WILL NOT BE CONSIDERED UNLESS YOU ATTACH ORIGINAL DETAILED ACCOUNTS AND COPY OF PRESCRIPTION FOR EACH CHEMIST'S CASH SALE.

- 1 NAME OF POLICY HOLDER.....Policy No.....
- 2 NAME OF INSURED MEMBERId_No.....Pin.....
- 3 Box NoTown.....Code.....Mobile.....Email.....
- 4 PATIENT'S FULL NAMES M/NO
- 5 Are you Insured under any other medical expenses scheme, Work Injuries Benefit ACT (WIBA), Personal Accident, NHIF etc If so give particulars i.e. Name of Insurers, policy No. etc

II TO BE COMPLETED BY THE ATTENDING DOCTOR

A) SICKNESS:-

- (i) Nature of sickness
- (ii) When did sickness start?
- (iii) Did the patient suffer from this sickness before? If yes, when did it start and how frequent is it?
- (iv) In your opinion is this illness chronic or recurring?
- (v) Give details of treatment

B) ACCIDENTS :-

- (i) Date Time Place
- (ii) Was patient on duty/leisure?
- (iii) Nature of injuries
- (iv) Was accident caused by Third Party? If so, what action has been taken / contemplated?
- (v) Date of full recovery

C) OPERATIONS :-

- (i) When was possibility of operation first known, suggested or considered?
- (ii) Nature of operation
- (iii) Date of operation

I certify that the above treatment was administered by me or carried at my instructions by other practitioners and establishments.

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 DOCTOR'S SIGNATURE & QUALIFICATION DOCTOR'S STAMP DATE

DECLARATION

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

Dated Patient's/Guardian's signature

DETAILS OF THE EXPENSES

ITEM NO.	DESCRIPTION	AMOUNT