COVID 19 INSURANCE POLICY - CLAIM FORM

This form should be completed in **BLOCK LETTERS**, signed by the member and the doctor on whose recommendation the treatment was undertaken, and returned to us with all **relevant documents including medical reports** supporting these expenses attached.

PART I: Hospital Details

Hospital/Facility name.....

Address..... Location .....

E-mail address..... Tel. No.....

PART II: Member to fill

Member's name.....Member No.....

Address..... Tel. No.....

E-mail address..... ID No..... Age.....

PART III: Doctor to fill

1. Date when claimant was first medically examined .....

2. Nature or Condition which necessitated treatment.....

3. Clinical Summary.....

4. Has the patient Tested Positive for Covid 19.....

5. If Yes, What was the Treatment given.....

6. Was the patient put on Quarantine.....

7. If so for how many days .....

8. Does the claimant have an underlying pre-existing respiratory condition (If so, give details)? .....

9. Had the patient travelled outside Kenya and for how long?.....

The above-mentioned patient has undertaken the treatment specified on my recommendation:

Doctors Name.....Doctors Signature. .....

Doctors Qualification.....Telephone No.....

PART IV: Patient Declaration

I ..... Declare that all the statements given by me on this form are to the best of my knowledge true and complete. I authorize the Insurance Company to obtain medical information from the doctor I have consulted and shall submit to any medical examination(s) if so required by the Company.

Patient Signature..... Date. .....

GA Insurance Limited
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