MAYFAIR INSURANCE COMPANY LIMITED
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MAYFAIR
INSURANCE

Medical Insurance Claim Form

This form should be completed in BLOCK letters, signed by the Member and the Medical Advisors on whose recommendation the treatment undertaken and returned to us with all relative accounts.

In your own interest, full information should be given.

All information supplied will be treated in strict confidence.

No admission of Liability is made BY Underwriters by the issue of this form.

Name of your Employer _____

(Group Schemes only)

Member's Name _____

Address _____

Patient's Name _____

Nature or condition which necessitated treatment (in BLOCK letters) _____

_____

Date when patient first medically examined for condition _____

Have you suffered from this complaint previously, if so, when

N.B Receipted accounts or vouchers supporting these expenses must be attached

	DETAIL OF EXPENSES	Shs	Cts.
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
	Total		

Name and Address of Medical Adviser _____

_____

The above mentioned Patient has undertaken the treatment specified on my recommendations.

Signature of Medical Adviser _____ Date _____

I hereby declare that all statements given by me on this form are to the best of my knowledge true and complete.

Signature of Member _____ Date _____