

**Sanlam General Insurance Limited**  
Gateway Place, Jakaya Kikwete Road  
P.O. Box 60656-00200 Nairobi, Kenya

**T** +254 (0)20 278 1000  
**M** +254 (0)707 131 313  
**E** [preauths@sanlam.co.ke](mailto:preauths@sanlam.co.ke)  
**W** [www.sanlam.co.ke](http://www.sanlam.co.ke)

**> Personal details**

Employee Name:   
Membership No:   
Name of Policy holder/Employer:   
Patient's Name:   
Date of Birth:  Relationship of Patient to Employee:   
Hospital:

**> For official use only**

1. Diagnosis:

2. How long has the patient suffered the same ailment?

3. Nature of treatment:

4. Dates of any previous treatment for this ailment: 5. Is a specialist referral, admission or specialized diagnostic services required? Yes  No 

6. Physician's:

Signature: \_\_\_\_\_

Stamp: \_\_\_\_\_

Date: \_\_\_\_\_

**> Declaration**

I \_\_\_\_\_ do hereby authorize any doctor, hospital, clinic or medical provider, insurance company, institution or person who has any record or information about me and/or my family members to provide Sanlam General Insurance Company Limited with complete information including hospitalization.

I have also been advised and have understood the various exclusions i.e. illness or procedures that are not covered. Any photocopy of this authorization shall be taken as the original copy.

Members signature: \_\_\_\_\_ Date: \_\_\_\_\_