

## CLAIM FORM FOR PERSONAL ACCIDENT

Notes: If the claimant is too ill to write, this form should be completed by the responsible person in charge of him/her. No claim can be considered without the properly completed medical certificate overleaf, furnished at the expense of the claimant.

POLICY NO. : \_\_\_\_\_ Date of Last Payment of premium : \_\_\_\_\_

### SECTION 1 - EMPLOYER DETAILS

1. Name of Employer \_\_\_\_\_
2. Contact Details: (tel): \_\_\_\_\_ (web): \_\_\_\_\_  
 ID NO: \_\_\_\_\_ PIN NO: \_\_\_\_\_  
 (email): \_\_\_\_\_  
 (postal): \_\_\_\_\_ (code): \_\_\_\_\_ (town/ city): \_\_\_\_\_

### SECTION 2 - INJURED EMPLOYEE DETAILS

4. Injured Employee Names: \_\_\_\_\_  
 (mobile): \_\_\_\_\_ (email): \_\_\_\_\_  
 (postal): \_\_\_\_\_ (code): \_\_\_\_\_ (town/ city): \_\_\_\_\_
5. (a) Occupation? \_\_\_\_\_ (b) Age? \_\_\_\_\_ (c) Married or Single? \_\_\_\_\_  
 (d) Height? \_\_\_\_\_ (e) Weight? \_\_\_\_\_

### IF ACCIDENT, PLEASE STATE ::

6. Date \_\_\_\_\_ Time \_\_\_\_\_
7. Were you perfectly sober ?  Yes  No If "NO", give details :  
 \_\_\_\_\_
8. Where did accident occur? \_\_\_\_\_
9. How did it happen and what were you doing at the time ?  
 \_\_\_\_\_

### 10. Name and addresses of witnesses

Name	Tel. No. and Address

### THE INJURY / ILLNESS

11. Details of injury/illness  
 \_\_\_\_\_
12. Have you previously suffered injury to the same part, or a similar illness ?  Yes  No
13. Date you were first totally incapacitated \_\_\_\_\_  
 Date of doctor's first attendance \_\_\_\_\_  
 Name of doctor first attending \_\_\_\_\_  
 Who is your usual doctor? \_\_\_\_\_

14. For what previous injury or illness have you received medical attention? Please give full details with dates.

[Redacted area]

15. What occupations have you followed since the date of proposal for this insurance ?

[Redacted area]

16. Have you been prevented, on your doctor's advice, from engaging in work of any kind?  
If YES, give dates and state "continuing" if necessary.

Yes  No

[Redacted area]

17. Are you now capable of any kind of work ?  
If YES, what work and from what date ?

Yes  No

[Redacted area]

18. Are you now capable of full work?  
If YES, from what date?

Yes  No

[Redacted area]

19. Are you entitled to claim compensation for this accident / illness from any other insurer?  
If YES, give particulars

Yes  No

[Redacted area]

DECLARATION

I declare that the particulars upon this form are true and complete.

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

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

(Rubber Stamp if Corporate)

## MEDICAL CERTIFICATE

THIS CERTIFICATE IS TO BE COMPLETED BY A DULY QUALIFIED AND REGISTERED MEDICAL PRACTITIONER AT THE INSURED'S EXPENSE  
**NB:** BY TOTAL DISABLEMENT, IT IS UNDERSTOOD THAT THE CLAIMANT IS PREVENTED BY THE INJURY FROM ATTENDING TO ANY PORTION OF HIS DUTIES

1. Name of Patient?
2. When were you first consulted?
3. What injuries has the patient sustained ?
4. When and for what previous injuries and illness have you attended him ?
5. To what is the injury / illness directly attributable ?
6. If accident, have you reason to believe the claimant was not sober or was under the influence of drugs at the time?  Yes  No  
 If "Yes", give details :
7. Is or was the claimant suffering from any other complaint which might have contributed to his present condition or might delay recovery?  Yes  No If so please give details :
8. For how long has the patient been totally incapable of any kind of work: FROM  TO
9. For how long has the patient been partially incapable of any kind of work: FROM  TO
10. On the basis of the scale below, do you consider that the patient has suffered any permanent disability?  Yes  No  
 If so, please indicate the percentage applicable

**DECLARATION**

Name of Medical Practitioner   
 Address   
 Qualifications

Date \_\_\_\_\_ Signature and Rubber Stamp \_\_\_\_\_

Injury	Scale of Permanent Disablement (%)
Loss of both hands	100%
Loss of both feet	100%
Complete and irrecoverable loss of sight in both eyes	100%
Loss of one hand and one foot	100%
Loss of one hand or one foot together with the complete and irrecoverable loss of sight in one eye	100%
Complete and incurable insanity	100%
Complete and incurable paralysis	100%
Loss of right arm or hand	60%
Loss of left arm or hand	50%
Loss of one leg or one foot	50%
Complete and irrecoverable loss of sight in one eye	50%
Loss of thumb of right hand	20%
Loss of thumb of left hand	15%
Loss of index finger of right hand	15%
Loss of index finger of left hand	10%
Loss of any other finger of right hand	6%

Injury	Disablement (%)
Loss of any other finger of left hand	5%
Loss of big toe	5%
Loss of any other toe	3%
Complete and irrecoverable loss of hearing in both ears	40%
Complete and irrecoverable loss of hearing in one ear	10%

**NOTE :**

In the case of permanent disablement not specified in this table please assess in accordance with the degree of disablement by referring to the percentage indicated above without taking into account the occupation of the patient

1. In the event of the loss or loss of use of more than one of the aforementioned members or organ the percentages shall be aggregated but the total amount of the benefits payable shall in no case exceed 100% of the sum appropriate to the Insured person concerned written above..
2. When the limb or organ which was partially useless prior to an accident covered by this policy becomes completely useless as the result of such accident the amount payable shall be equal only to the loss of use occasioned by the accident. No payment shall be made in respect of the loss of a limb or organ which was useless prior to the accident.
3. When an Insured person is left handed the percentage above relating to the right hand shall apply to the left hand and vice versa.