FIRST INSURANCE COMPANY LIMITED
"Service Beyond Expectation"
A Subsidiary of NicozDiamond Insurance Limited, Zimbabwe

Plot No.1 Kyadondo Road
P.O.Box 5245, Kampala-Uganda
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PERSONAL ACCIDENT / GROUP PERSONAL ACCIDENT CLAIM FORM

Dear Sir/Madam,

With reference to your recent notification of an accident, please give full details on the Claim Form on the next page, and request the Doctor attending you to complete the attached Medical Certificate. You should attach the Medical Certificate to the Claim Form and deliver the documents to us with the minimum of delay.

As Medical Certificates will be required at fortnightly intervals during periods of total or temporary disablement, additional Medical Certificate Forms can be supplied at your request should disablement be estimated to last over TWO WEEKS.

1. INSURED'S DETAILS

Name of Insured (in full) .....

Address.....

.....

Email.....Telephone.....

Occupation/Business.....

Age Height Weight

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2. PHYSICIANS DETAILS

Name of Doctor in attendance….....

Address.....

.....

Please note: The Medical Certificate attached should be filled in by the Doctor mentioned above.

Is s/he your usual Medical Attendant? Date on which s/he was first consulted

.....Yes.....No...../...../.....

When can you be seen?

.....

How long have you have been

1. Wholly unable to attend to any portion of your profession or occupation?

From...../...../...../.....to...../...../.....

2. Able to attend partly to your profession or occupation?

From...../...../...../.....to...../...../.....

Provide Names and Addresses of any other Insurer or Society OR club from whom you are entitled to benefit in respect of the same accident/illness.

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Amounts of such benefits…….....

3. DESCRIPTION OF ACCIDENT

Date.....Time.....pm./am

Place….....

Please give full details of accident indicting what you were doing at the time

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What injuries have you sustained? (If an eye, hand or arm, foot or leg, please state whether left or right).

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Have you previously suffered from similar injuries? If so, please give details.

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Name and addresses of witnesses

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When did incapacity start?

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4. NOTES FOR INSURED

Any fee for Medical Certificate is payable by the Insured.
Further Medical Certificates are required at fortnightly intervals during periods of total temporary disablement.
Insured may be required to submit to Medical Examination on behalf of and at the expense of the Company in connection with this claim.

DECLARATION

I/ We the above named, do hereby to the best of my/ our knowledge and behalf, warrant the truth of the foregoing statements in every respect; and I/ We agree that if I/We have made, or in any further declaration to the company in respect of the said loss, shall make any false or fraudulent statement or any suppression or concealment my / our claim shall be absolutely forfeited and the Policy shall henceforth be null and void.

I hereby declare that the above statements are true in every respect and are made without reservation and I claim to be paid the benefit due under the policy.

Date.....Insured's Signature.....

Name.....

PRIVATE AND CONFIDENTIAL

POLICY NO……CLAIM NO…….....

MEDICAL CERTIFICATE

NOTE: This for is to be completed by the Claimant's Medical Attendant whose replies should be as full as possible.

1. CLAIMANT (Name in full)	……..……... ……..……	
2. The nature and extend of injuries (If to a limb, state whether right or left)	……..……... ……...…… ……...……	
3. The cause of the accident, so far as known to you	……..……... ……...……	
4. a. Date of your first attendance upon him in consequence of the injuries b. Are you still in attendance	a.……..……... b.……	
5. Are you his usual Medical Attendant if so, how long have you known him, and for what have you attended to him/her?	Yes……No…… ……	
6. a. Are his/her symptoms (i) due exclusive to the accident, or (ii) traceable disease, infirmity or any other cause? b. Has she/he ever suffered from gout, rheumatism, diabetes or fits? c. Is there anything in his/her medical history which may have contributed, directly of indirectly, to the accident or which may be likely to retard his/her recovery? d. Have you any reason to suppose that he was under influence of intoxication at the time of the accident?	Yes……No…… ...…… Yes……No…… Yes……No…… Yes……No……	
7. State the time within your knowledge, that the claimant has been as the direct and sole consequence of the injuries sustained, necessarily confined to his bedroom, or house. If still so confined state, to which and the probable duration of confinement to each.	TEMPORARY TOTAL DISABLEMENT	TEMPORARY PARTIAL DISABLEMENT
	From ……..…... To ..... (Both days inclusive)	From ……..…… To……....…

8. a. Has he/she been able to attend to any portion of his business or occupation? b. If so, from what date? c. If not, please state probable date: i) of his/her being so able ii) of his/her complete recovery	Yes……No…… b…… c……... ...…… ……..
9. Is there now any permanent disability? a. If so please state the degree/ percentage of Permanent Incapacity. b. b. If not give date of recovery	Yes……No…… a……... …… b……... ...……
10. Any further remarks …… …… ……	

DECLARATION

I hereby certify that the above named met with the accident referred to and that the foregoing statements are correct.

Signature……

Name……..……

Qualification……..……

Address……..……

Date……..……..

TOTAL DISABLEMENT occurs when the Insured is wholly prevented from attending to his business or occupation; **PARTIAL DISABLEMENT** when prevented from attending to a sustained portion thereof.