FIRST INSURANCE COMPANY LIMITED
Service beyond expectations

Plot 3A, Luthuli Avenue, Bugolobi.
P.O. Box 5245 Kampala, Uganda
Tel: +256 414 342 863 | +256 414 233 750
Email: fico@fico.co.ug

**PERSONAL ACCIDENT CLAIM/GROUP PERSONAL ACCIDENT**

Dear Sir/Madam,

With reference to your recent notification of 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 temporary disablement, additional Medical Certificate Forms can be supplied at your request should disablement be estimated to last over two weeks.

**1. Insured**

Policy No. _____

Name _____

Address _____

Profession or Occupation (if in business state exact nature)
(state all if more than one) Tel. No. _____

Age Height Weight

**2. General**

Name and address of Doctor in attendance
Note: The Medical Certificate attached should be completed by this Doctor.

_____

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

_____

When can you be seen?

_____

How long have you been
(a) Wholly unable to attend to any portion of your profession or occupation?

from / / to / / /

(b) Able to attend partly to your profession or occupation?

from / / to / / /

Names and addresses of any other Insurer or Society or Club from which
You are entitled to benefit in respect of the same accident/sickness

Amount of such benefits

**3. Accident**

Date Time a.m./p.m

Place

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

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

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

Name and addresses of witnesses

When did incapacity start?

**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.

## 5. Declaration

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.

Signature …….. Date ……

**PRIVATE AND CONFIDENTIAL**

Claim No. ……..

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# 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<br>(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<br>b) Are you still in attendance | a)<br><br>b) | |
| 5 | Are you his usual Medical Attendant if so, how<br>long have you known him, and for what have<br>you attended to him/her? | | |
| 6 | a) Are his/her symptoms (i) due exclusive to the accident, or (ii) traceable disease, infirmity or any other cause?<br>b) Has she/he ever suffered from gout, rheumatism, diabetes or fits?<br>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?<br>d) Have you any reason to suppose that he was under influence of intoxication at the time of the accident? | a)<br><br>b)<br><br>c)<br><br>d) | |
| 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<br><br>From ……...<br>To .....<br>(Both days inclusive | TEMPORARY PARTIAL DISABLEMENT<br><br>From ……...<br>To…… |

| | | |
|---|---|---|
| 8 | a) Has he/she been able to attend to any portion of his business or occupation?<br>b) If so, from what date?<br>c) If not, please state probable date:<br>i) of his/her being so able<br>ii) of his/her complete recovery | a)<br><br>b)<br>c)<br>i)<br>ii) |
| 9 | Is there now any permanent disability?<br><br>a) If so please state the degree/ percentage of Permanent Incapacity.<br><br>b) If not give date of recovery | |
| 10 | Any further remarks | |

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

Signature……

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.