PERSONAL ACCIDENT CLAIM FORM

(If unable to reply personally, this form may be filled in on behalf of the claimant)

Jubilee Insurance Centre, Parliament Avenue
P.O Box 10234, Kampala, Uganda
Telephone: +256 414311701 +256 761002060
Email: jazug@allianz.com

"To avoid delay and unnecessary correspondence in the processing of your claim please observe the following requirements:-
1. Ensure that both the claim form and the medical certificate are properly completed:
2. Supporting documents or copies thereof plus original medical bills incurred, if any, must be submitted with the claim form.".

Claimant' name (in full) _____

Address _____

Present Occupation _____ Present Age _____

Policy No. _____ Date of payment of last Premium _____

1. (a) Date of Accident? _____ (b) Where did it occur _____ c) Describe fully how it happened? (d) Give name, occupation and address of a witness of the Accident	1 (a) _____ Time: _____ O'clock ____ M (b) _____ (c) _____ (d) Name _____ Occupation _____ Address _____
2 (a) Describe the nature and extent of the injuries you have received. (b) Give names and addresses of the Doctors who have attended you for these injuries.	2 (a) _____ (b) Names: _____ Address: _____
3) (a) State the number of days you have been ENTIRELY confined to your Bed, Room or House.. (b) If you are still confined to your Bed or Room or House, state which. 4. (a) State the extent and duration of your inability to attend to your business or occupation. (b) If still disabled state how much longer the disability is likely to continue.	3. (a) To Bed for _____ days from _____ to _____ To Room for _____ days from _____ to _____ To House for _____ days from _____ to _____ (b) _____ 4. (a) I have been diasbled PARTIALLY for _____ days from _____ to _____ WHOLLY for _____ days from _____ to _____ I am now _____ disabled (Insert "wholly" , "partially), or "not at all") (b) _____

5. Have you since the accident personally directed or supervised or given any attention whatsoever to any part of your business or occupation? If so, give full particulars and dates.	5.
6. (a) Are you entitled to receive compensation from any other company or other source? If so, give full particulars.	6. (a)
(b) Have you ever claimed compensation from any company? If so give full particulars.	(b)
7. Are you perfectly free from any Physical Defect, infirmity or Disease?	7.
8. Are you at the present time able to state the amount for which you are willing to settle the claim? (The compensation is based upon the actual period of disablement.)	8.

DECLARATION

I, the undersigned, hereby declare that I am the person referred to in the above statement, which is true in every respect, and made without reservation.

I hereby authorise the company to apply to my Medical Attendant mentioned above, for a Report to be firnished at my expense in the form used by the Company for the ourpose.

Date _____ Signed _____

NOTE: The Medical Certificate must be completed by your Doctor before this Claim Form is forwarded to the Company

MEDICAL CERTIFICATE

In order to establish his Claim, the Claimant must obtain and forward to the Company a certificate from a duly qualified and registered Medical Practitioner, and it is essential that this form be filled up as minutely as possible so the Medical Officer of the Company may properly understand the nature of the case.

The Medical Attendant of the Claimant is requested to state:-

1. The Name and Occupation of the Claimant:

2. The exact nature and extent of the Injuries caused by the accident. If a Hand or an arm, a Foot or a Leg. State whether it is the RIGHT or LEFT.

Regions Injured	Nature and extent of

3. Whether the Claimant has suffered or is now suffering from any constitutional or local disease or Physical infirmity. If so state the nature of such disease or infirmity and to what extent it affects the disablement.	3.
4. (a) When and where he first attended the Claimant? (b) Are you still attending him?	4. (a) at _____ At _____ o'clock _____ M _____ on the _____ day of _____

5. To what extent the above accident injuries have necessarily disabled the Claimant from giving attention to business.	Claimant has been disabled TOTALLY for _____ days PARTIALLY for _____ days	Claimant is now * _____ disabled *Insert totally, partially or not at all as the case may be.	The further disability (if any) will in my opinion continue. for _____ entirely for _____ entirely from the present time.

Total Disablement arises when the Claimant is rendered completely incapable of attending to any part of his ordinary proffesions, business or occupation. Partial Disablement arises when the Claimant is a little injured, or has so far recovered from injuries as to be capable of attending to some portion of his ordinary profession, business or occupation.

6. (a) If the Claimant is now, in any way, attending to business, on what day he first commenced doing so after the accident.

6. (a)

(b) If not whether you consinder Claimant fit personally to supervise or direct his Business or Occupation.

(b)

7. Have you any reason to think that the patient was not perfectly sober at the time of the accident?

7.

8. Is there any Information, professional or otherwise that you consinder should be known to the company.

8.

REMARKS: If any:

I certify that I have satisfied myself by personal examination that the Claimant has sustained an accident causing injuries as above described.

Signature _____ **Qualifications** _____

Date _____ **Address** _____

_____