CBZ Insurance Company (Private) Limited
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P O Box WTG 9120, Harare, Zimbabwe
Phone: +263 -4-799234 – 38, Fax: +263 -4- 735417

ACCIDENT AND SICKNESS CLAIM FORM

NOTE: If the claimant is unable to complete this form a member of his family or a friend may fill in on his/her behalf.

Name Of Claimant: …… Age: …… Policy No. :……

Business/Occupation: …… Tel No.: ……. (W) ……..(H)

Address: ……

ACCIDENT: -

Date Of Accident: ……. Time: ……..……. am/pm

Place Of Accident: ……

How it happened & what you were doing at the time: ……..

……..……..

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If accident was a Road Traffic Accident please see overleaf.

Nature Of Injuries: ……

Period Of Disablement: ……I have been wholly disabled for: ……..… Days,

From: ……..…….. till: ……..……..……..

I have been PARTIALLY DISABLED for: …….. days, from: ……

Till: …… I am now: ……

(Insert WHOLLY DISABLED, PARTIALLY DISABLED or NOT AT ALL DISABLED as applicable)

Names and Addresses of Witness: ……

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SICKNESS: In the case of Sickness or Disease state:-

(a) Nature Of Sickness or disease:-

(b) Date Of Commencement:

(c) Date when you were first unable to attend to your business in any way:

(d) Are you now attending to your business? If so state from what date.

(e) Have you ever had a previous attack of the disease or sickness from which you are now suffering. If so, give details with approximate date(s) & period(s) of incapacity

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(f) State name and address of doctor who first attended to you. Is he/she your usual Medical Attendant?

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(g) Are you insured against accidents disease or sickness with any other company. If so give details:-

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(h) Have you ever previously made a Claim for Accident, disease or sickness? If so, please give details

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Attach Medical Report

MOTOR VEHICLE ACCIDENT:

Vehicle Make: …… Reg. No: ……...

Registered Owner Of vehicle: …… Driver: ……

Address: …… ……..……..

…… ……..……..

…… ……

Detailed Account of Accident:

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DECLARATION:

I understand that if necessary, CBZ Insurance Co. have a right to access my Medical records in order to proceed with assessment of the claim. I hereby declare that the above statements are true in every respect and are made without reservation.

Name In Full: ……. Designation: ……..

Signature: ……..…… Date: ……..……..……..

IF FUNDS ARE TO BE TRANSFERRED DIRECTLY INTO AN ACCOUNT STATE:

Bank Name: …… Branch:……Acc Name: …… Acc. No. ……..