NICOZDIAMOND INSURANCE COMPANY LTD

INSURED: ……..… POLICY NUMBER: …….

Date sent to Claimant: ……..…. Date Received from Claimant: ……..

DECLARATION OF ACCIDENT

1.	Name in full		Age next Birthday
2.	Full address		Email address
3.	Present occupations (in full)		
4.	Policy Number		
5.	Date of Accident	6. Time of day	'o' clock in the ……
7.	Give a dull description of the Accident, and where it happened, and also what you were doing at the time	……. …….. ……..	
8.	Give Name and Address of Witness	…….. ……..	
9.	State, as precisely as you can, what injuries you have sustained		

10.	How long have you been confined to the hospital, or House? If not confined to either, state the fact.	Hospital From…… To……	Your House? From……... to……...

11.	Describe the extent and duration of your Disability……	Totally 'Disabled for……..……days from…… to ……	Probable further duration of Disability (if any) Total ……..

12.	Have you been able since the Accident to give attention to any portion of your business or occupation? If so, to what extent and from what date?		
13.	State if claiming or entitled to Compensation for Disablement from any other policy or Society. If so, give particulars.		
14.	What are you now prepared to accept in full settlement of the claim?	……...…… ……	Day's Total Disablement Day's Partial Disablement

* It is necessary that this Form should be filled up minutely as possible to give an exact idea of the nature and extent of the Injury, and returned to the Nearest branch within seven days

The Medical Report Form must in every case be filled in, and the questions FULLY answered and attached to the claim form

NB- If the insured is too ill to write, this Form must be filled up and signed by someone else "for and on his behalf"

Signature……

Date ……

MEDICAL REPORT & CERTIFICATE

No claim can be considered unless a Medical Report is furnished

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To be obtained by the Insured from a Medical Practitioner Registered by Act

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By **Total Disablement** is understood an Injury wholly preventing the Claimant from attending to any portion of business.

Partial Disablement is when the Claimant is so slightly injured or has so far recovered as to be able to transact some portion of the business, but not the whole.

I do hereby certify that the within named party has received, from external violence, the following Accidental Injuries:-

Regions Injured. If limb, state Right or left	Fracture	Dislocation	Cuts or Tears	Contusion or Crushing	Sprains	Nature and Extent of Injuries

1. When was the claimant……..first seen by you after the Accident?

2. Are you still in attendance?

3. Between what dates (inclusive) has The Claimant been confined to the hospital or House by your direction, by the Injuries stated in the above Report?
   Hospital from…….. To…… House from…….. To…….

4. To what extent has the Claimant been necessarily disabled from business owing to injuries?
   Total Disabled …….days
   If still disabled, how long likely to continue? Totally……

5. Is the Claimant now able to attend to business in any way, and on what day was he/she able to do so after the Accident?

6. Was the Claimant at the time of the Accident, subject to any illness or disease *irrespective of the Injries:* if so, what was the nature thereof and to what extent may the recovery of Claimant be affected thereby?

GENERAL REMARKS-

I certify that the foregoing statements are correct.

Signed……. Designation…….

Date……20……. Address……