ZIMNAT INSURANCE COMPANY LIMITED

ZIMNAT

GROUP PERSONAL ACCIDENT CLAIM FORM

The Insured is required to state as fully & as accurately as possible the information asked for below:-

Name: Age:.....

Address:.....Height.....

Occupation: Weight …….

Policy No. Date Premium paid:

Date of accident: Place:

Details of incident:

Nature of injury:

Name and address of witness of accident:

Name and address of doctor attending you. :

Is he your usual medical attendant?

Extent of Disablement	**Dates**
How long have you been confined to bed?	From:.....to
How long have been confined to your house?	From:.....to
How long have you been wholly prevented from attending to all administrative and superintending duties?	From.....to
How long have you been prevented from attending to substantial portion of your administrative and superintending duties?	From.....to

Are you now wholly or partially prevented from attending to your administrative and superintending duties? Yes/ No .

Do you hold any other accident insurance:
If so, state name of company and amount of insurance.

Have you any suggestion to make for an immediate settlement?

If so, state amount you would be prepared to accept ……

I hereby declare that I am suffering from the accident described and claim compensation under the above policy in respect thereof; I hereby warrant the truth of the foregoing particulars in every respect and declare that the conditions of my insurance have been fully complied with; and that I have abstained from my usual occupation longer than absolutely necessary; and agree that if I have made or shall in any further declaration the directors may require of me in respect of the accident, make any false or untrue settlement; suppression or concealment, the policy shall be void, and my right to compensation absolutely forfeited.
For and on behalf of.....

Signature …… Witness …….

Date:

CERTIFICATE OF MEDICAL ATTENDANT

(To be furnished at the Insured's expense)

THE MEDICAL ATTENDANT OF THE CLAIMANT SHOULD READ THE NOTICE BELOW BEFORE FILLING UP THIS FORM.

Name of claimant:.....

Address:.....

Occupation: Age.....

Nature and cause of injury:.....

Whether the appearance of the injury is consistent with the account given of the accident:.....

Date on which you first attended claimant for this injury:

Has claimant been wholly prevented from attending to any portion of his business: Yes/No

if so how long?.....

Is claimant suffering from any disease or illness apart from his injury? : Yes/ No.....

And is there any illness or circumstances which may tend to retard recovery? If so, give particulars:

……

Between what dates do you consider:-

* Total disablement will last: .....

** Partial disablement will last:

.....

Present condition:.....

Remarks ……...

……

……

……

I hereby certify that the above-mentioned met with the accident referred to, the injuries he is suffering from are solely the result of the accident, and that the foregoing statements are correct.

Signature…… Address:

Qualifications ……... Date

* Temporary total disablement is described in the policy as such injury as shall disable and absolutely incapacitate the Insured from attending to any administrative and superintending duties.

** Temporary partial disablement is described in the policy as such injury as shall disable the Insured from attending to a substantial portion of his administrative and superintending duties.