PERSONAL ACCIDENT CLAIM FORM

INTRA AFRICA ASSURANCE COMPANY LIMITED

(Incoporated in Kenya)

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This form is issued without admission of liability, and must be completed and returned within seven days after its receipt. No claim can be admitted unless a medical certificate overleaf be furnished at the expense of the claimant.

Agency name: _____

1. INSURED'S DETAILS

Full name of claimant _____

Pin number(please attach copy): _____

Certificate of Registration/Incorporation/ID/Passport(Please Attach copy) _____

2. CONTACT DETAILS:

Mobile: _____ Email: _____

Postal: _____ Code: _____ Town/City: _____

Web: _____ Fax: _____ Tel: _____

Occupation: _____ Age: _____

When did the accident occur? State day, date and hour _____

Where did it occur? _____

Give full particulars of the cause and the injuries sustained _____

_____

Give names and addresses of any witnesses of the accident _____

_____

Give name and address of the Doctor who attended you. _____

_____

Name and address of your ordinary medical attendant _____

_____

State where and when a Medical or other Officer of the Company can visit you, if necessary.

_____

State the number of days you have been necessarily and entirely confined to Bed, Room or House, as the sole and direct result of the injuries sustained. **NB: BOTH DATES ARE INCLUSIVE.**

Place	No of Days	From (Date)	To (Date)
Bed			
Room			
House			

If still confined to any, state which:_____

Have you in any way attended to business or work during the above period?_____

Have you previously claimed or received compensation under an Accident and/or Sickness policy?

_____

Are you insured elsewhere? If so, give name of each Company or Insurer and amount you are entitled to claim.

_____

DECLARATION.

I hereby declare that I have received the injuries above described, and warrant the truth of the foregoing particulars in every respect, and agree that if I have made, or if, shall make any false or untrue statement, suppression or concealment, my right to compensation shall be absolutely fortified.

I claim to be paid the sum of Kshs:_____ per week, or the total sum of Kshs:_____ which I agree to accept in full settlement of my claim on the company.

Signature:_____ Date:_____