PERSONAL ACCIDENT MEDICAL REPORT

INTRA AFRICA ASSURANCE COMPANY LIMITED

(Incoporated in Kenya)

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This form to be completed by the Claimant's Medical Attendant whose replies should be full as possible.

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: _____

Nature and extent of injuries: (If to a limb, state whether right or left): _____

_____

The cause of the accident, so far as known to you: _____

Date of your first attendance upon him in consequence of the injuries sustained: _____

Are you still in attendance? _____

Are you his usual Medical Attendant, and if so, how long have you known him, and for what have you attended him?

_____

Due to exclusively to the accident? _____

Traceable to disease, infirmity or any other cause? _____

Has he ever suffered from Gout, Rheumatism, Diabetes or Fits? _____

Is there anything in his medical history which may have contributed, directly or indirectly, to the accident, or which may be likely to retard his recovery? _____

_____

Have you any reason to suppose that he was under the influence of intoxicants at the time of the accident?

_____

State the time, within your knowledge, that the claimant has been, as direct and sole consequence of the injuries sustained necessarily confined to his bedroom or house. **(BOTH DATES INCLUSIVE)**

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

Has he been able to attend to any portion of his business or occupation?_____Yes/No

If so, from what date:_____

If not, please state probable date of his being so able_____

Of his complete recovery:_____

Is there now any disability?_____Yes/No

If not, please give date of recovery:_____

Any further remarks:

_____

_____

_____

_____

DECLARATION.

I hereby certify that the above named met with the Accident referred to any that the foregoing statements are correct.

Signature:_____ Qualification:_____

Address:_____ Date:_____

TOTAL DISABLEMENT occurs when the Insured is wholly prevented from attending to his business or occupation.

PARTIAL DISABLEMENT occurs when prevented from attending to a substantial portion thereof.