Britam
With you every step of the way

PERSONAL ACCIDENT CLAIM FORM

IMPORTANT Please answer every question

Policy No.

Name of Insured:

Address:

Telephone /Cellphone: Email:

Claimant:

Designation:

Type of work
(describe duties in full)

Basic salary/earnings (Per annum): Date of Accident:

Place of Accident Time:

(1) How did the accident occur?:

(2) What were you doing?:

(3) Was it fatal?: YES NO

(4) If not fatal, state the apparent injuries?

(5) Have you had similar injuries YES NO

(6) How long have you been totally disabled

(7) Have you now resumed your employment duties? YES NO

(8) How long have you been bed ridden?

(9) How long have you been confined to your house?

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10. To which hospital were you admitted?

11. Were you operated on? YES NO

12. Name and address of the doctor who operated:

13. Name and address of the doctor treating you:

14. Is he your usual doctor? YES NO

15. Have you undergone medical or surgical treatment during the past five years? YES NO

If yes give detailed particulars:

16. Name and address of any witness:

17. Are you insured for personal accident with any other company? YES NO

If yes give address and branch

18. Do you hold a life policy?

If yes give name and address of insuring company.

I hereby declare that the aforegoing statements are true and within my knowledge and belief

Dated at this day of 20

Insured Signature

MEDICAL CERTIFICATE

(To be completed by a qualified Medical Practitioner)

(1) Name of patient

(2) What injuries has the patient sustained?

(3) X-ray results:

(4) When were you first consulted?

(5) Has the patient sustained any permanent disablement? YES NO

Permanent Disablement %

(6) How long has the patient been totally disabled?

Totally : From To

(7) Has the patient any disease or physical defect and if so, of what nature?

(8) If (7) Above is in the affirmative. has this aggravated in any way the present injury and if so, what is the percentage of aggravation?

(9) On the basis of the continental permanent disability scale showing below, do you consider that the patient has suffered any permanent disability?:

If so, what is the percentage?:

SCALE OF DISABLEMENT UNDER EVENT B OF THE POLICY

(1) Permanent Disablement			
	Loss of two limbs or sight of two eyes or one limb eye		100%
	Loss of one limb one eye		50%
	Total and irreversible paralysis		10%
(2) Permanent Partial Disablement			
	Loss of four fingers		35%
	Loss of thumb - both phalanges		25%
	- one phalanx		10%
	Loss of index finger - three phalanges		10%
	- two phalanges		8%
	- one phalanx		4%
	Loss of other fingers -Three phalanges		8%
	- two phalanges		6%
	- one plalanx		4%
	Loss of all toes		25%
	Loss of great toe - one phalanx		5%
	- two phalanges		2%
	Loss of other toe		2%
	Total and permanent loss of hearing		
	- both ears		50%
	- one ear		10%

Where the injury is not specified the Company will adopt a percentage of disablement which in its opinion is not inconsistent with the provisions of this compensation scale.

Name of Medical Practitioner

Address

Telephone

Date

Signature