Better. Simple. Life.

SalamaSure Claim Form
(Personal Accident)

1. The attending doctor should complete the medical certificate with minimum delay
2. In addition to this claim form, please submit the following
   - Original medical reciepts
   - Copy of ID
   - Certified copy of burial permit (in case of death)
   - Certified copy of death certificate (in case of death)
   - Police abstract report (incase of road traffic accident
3. All questions on this form must be answered fully and clearly

REMEMBER: Incomplete answers will lead to delayed processing of your claim.

Insured's Details

Full Name _____
Last Middle First

Policy Number _____ ID Number _____

Accident Details

Date of Accident _____ Time _____ Place _____

1. Please give details of accident and injuries, stating how exactly it occured _____

_____

Were you engaged in your ocupation when the accident happened Yes ☐ No ☐

Were there eyewitnesses to the accident Yes ☐ No ☐

Witness _____ Contact _____

Witness _____ Contact _____

Declaration

I, the above named applicant, declare that all the statements made above are complete and true to the best of my knowledge and belief.

Signature _____ Date _____

Name: _____ Title _____

Medical Certificate (to be filled by doctor)

Any fee for this certificate is payable by the insured.
Total temporary disablement occurs when the patient is wholly unable to attend to all duties related to their profession or occupation because pf the injury.
Partial temporary disablement begins when the patient is able to attend to any portion, but not all, of the occupation. When answering below, please consider if the patient is totally or partially disabled.

Are you the patient's usual Medical attendant? Yes ☐ No ☐

How long have you known him? Yes ☐ No ☐

Please give details of injuries & Medication prescribed_____

_____

When did you first attend the claimant for the current injuries? Yes ☐ No ☐

Do the injuries seem consistent with the description of accident given by the insured? Yes ☐ No ☐

How long has the patient been totally disabled? From_____To_____

How long has the patient been partially disabled? From_____To_____

Has the patient any disease, disability or physical defect currently, apart from the effects of this accident? Yes ☐ No ☐

If so, please give details_____

If he has, to what extent, in your opinion; (i) Was the accident attribute to it?_____

(ii) Is recovery retarded by it?_____

Based on the scale overleaf only, do you consider that the patient has suffered any permanent disability? Yes ☐ No ☐
If so, indicate the percentage applicable _____ %

Name_____

Qualifications_____

Address_____

Telephone_____Fax_____

Email_____

Doctor's Signature_____ Doctor's Stamp

Date_____

MEDICAL EXPENSES shall mean the cost of medical surgical or other remedial attention treatment or appliances given or prescribed by a qualified medical practitioner.

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