

**NATIONAL INSURANCE COMPANY LIMITED
PERSONAL ACCIDENT CLAIM FORM**

(If the Insured is unable to complete this form, it may be filled up on his behalf.)

The Insurers do not admit liability by issuing this form

Name of Insured : _____ Age : _____

Name of Life Insured : _____ Age : _____

Address in full : _____

Profession or Occupation : _____

(Please indicate whether Master Superintending, Master working or Workman)

Policy No: _____ Renewal : _____ Claim No: _____

1. State when and where the accident :
took place Give date and hour.

2. State how it happened and what the :
insured/the Life Insured was doing
at the time.

3. State as fully as you can the nature :
and extent of the injuries sustained.

4. Give the name and address of the :
Doctor attending the Insured/the
Life Insured for these injuries.
 - Is he the usual Medical :
Attendant?

 - Has any other Medical man :
been consulted

5. If the Insured/the Life Insured is still :
disabled, please indicate when he/she
is likely to be fit to resume usual
business or occupation-either wholly
or in part.



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Policy No: _____ Renewal : _____ Claim No: _____

1. State when and where the accident took place Give date and hour. :

2. State how it happened and what the insured/the Life Insured was doing at the time. :

3. State as fully as you can the nature and extent of the injuries sustained. :

4. Give the name and address of the Doctor attending the Insured/the Life Insured for these injuries. :
 - Is he the usual Medical Attendant? :

 - Has any other Medical man been consulted :

5. If the Insured/the Life Insured is still disabled, please indicate when he/she is likely to be fit to resume usual business or occupation-either wholly or in part. :



MEDICAL CERTIFICATE

Claims must be Supported by medical Evidence furnished by the Insured and at his expense.

1. (a) Name of Claimant (b) Sex (c) Age

2. (b) Nature and cause of accident
(b) If to eye or limb, state left or right
(c) Whether the appearance of the Injuries are consistent with the account given of the accident.

3. Date on which you first attended Claimant for this injury

4. Has Claimant been totally prevented from attending to any portion of his business ? If so how long ?

1. Is Claimant suffering from any disease or illness apart From his injury and is there any illness by circumstances Which may tend to retard recovery? If so, give particulars?

2. Present Condition

7. How long from the happening of the Accident do you consider Total disablement will last ?

Having personally examined the above named Insured I certify that the above statements are correct and that the injured person is necessarily disabled by the Accident referred to

Signature _____

Name&Qualification _____

Address _____

Date _____

REMARKS FOR EXTRA DETAILS

