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The issue of this form is not an admission of liability Claim No.:

PERSONAL ACCIDENT/CLAIM

NOTES: If the claimant is too ill to write, this form should be completed by the responsible person in charge of him/her.

No claim can be considered without the properly completed medical certificate overleaf, furnished at the expense of the claimant.

Full name of claimant .... Policy No.......................................…………..

Address .... Tel. No...…………..

.... Age...……………

.... Height ....……………

Occupation .... Weight ....…………..

IF ACCIDENT, PLEASE ALSO STATE:

Date and time of accident ....…………Were you perfectly sober? ....…….

Where did accident occur? ....…………………..

How did it happen and what were you doing at the time? ………………………………………………………………….

....

………………………………………………………..

Names and addresses of witnesses ....…………………..

Details of injury/illness...

……………………………

Have you previously suffered injury to the same part, or a similar illness? ....………………..

Date you were first totally incapacitated .... ….Date of doctor's first attendance ....…………

Name of doctor first attending .. ..…………………

Who is your usual doctor?..……………………..

For what previous injury or illness have you received medical attention?

………………………………………………..

Please give full details with dates...... ....…………………

What occupations have you followed since the date of proposal for this insurance? ....

…………………………..

....

…………………………………………………………

Have you been prevented, on your doctor's advice, from engaging in work of any kind? **YES/NO.**

If YES, give dates: **FROM** .... **TO** .... (state "continuing" if necessary).

Are you now capable of any kind of work? **YES/NO**

If YES, what work and from what date? ....

…………………

Are you now capable of full work? **YES/NO**.

If YES, from what date?

………………………………………………………………………………………………………..

Are you entitled to claim compensation for this accident/illness from any other insurer? **YES/NO.**

If YES, give

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particulars ....

I declare that the particulars upon this form are true and complete.

Date .... Signature of Insured...

Medical certificate overleaf

MEDICAL CERTIFICATE

THIS CERTIFICATE TO BE COMPLETED BY A DULY QUALIFIED AND REGISTRED MEDICAL PRACTITIONER AT THE INSUREDS EXPENSE

NB: BY TOTAL DISABLEMENT, IT IS UNDERSTOOD THAT THE CLAIMANT IS PREVENTED BY THE INJURY FROM ATTENDING TO ANY PORTION OF HIS DUTIES

1. Full name of Patient ....……………………………………..

2. When were you first consulted? ....…………………………….… ……….

3. What injuries has the Patient Suffered?

………………………………………………………………………………….

4. Date of your first attendance .... Are you still in attendance?

………………………………………..

5. To what is the injury/illness directly attributable ?

……………………………………………………………………

6. If an accident, have you reason to believe the Patient was not sober or was under the influence of drugs at the time of the accident?…………………………...

……………………………………

7. Is or was the Patient suffering from any other complaint which might have contributed to his present condition or might delay his recovery? If so please give details…..

8. For how long has the patient been totally incapable of any kind of work? **From** …………**To**……………………

9. For how long has the patient been partially incapable of any kind of work? **From** ……………**To**…………………

10. On the Scale below, do you consider that the Patient has suffered any permanent disability?……………….. ……….

11. If so please indicate the percentage applicable...………

Name of Medical Practitioner ....

Qualifications……………………………............

Address (Physical and Postal)..

…………………..

Date…………………………Signature…………………………………….Rubber Stamp………………………

	Permanent disability shall mean	**Percentage of Compensation**
(a)	loss by physical separation at or above the wrist ankle of one or more limbs	100
(b)	permanent and total loss of whole eye or loss of sight_______________	100
	sight of eye except perception of light____________________________	75
(c)	permanent and total loss of hearing both ears______________________	100
	one ear____	25
(d)	permanent and total loss of speech______________________________	100
(e)	injuries resulting in permanent total incapacity from following usual occupation or any other occupation for which such person is fitted by knowledge or training ____	100
(f)	loss of four fingers____	70
(g)	Loss of thumb - both phalanges________________________________	25
	loss of one phalanx____	10
(h)	loss of index index finger_____________________________________	10
	two phalanges____	8
	one phalanx____	4
(i)	loss of middle finger -Three phalanges___________________________	6
	two phalanges____	4
	one phalanx____	2
(j)	loss of ring finger - three phalanges_____________________________	5
	two phalanges____	4
	one phalanx____	2
(k)	loss of little finger -three phalanges_____________________________	4
	two phalanges____	3
	one phalanx____	2
(l)	loss of metacarpals -first or second (additional)____________________	3
	third, fourth or fifth 9additional)_______________________________	2
(m)	loss of toes - all on one foot ___________________________________	30

great, both phalanges	5
great, one phalanx	2
other than great, if more than one toe lost, each	2

(i) Where the injury is not specified, the company will pay such sum as, in their opinion, is consistent with the above provisions.

(ii) Permanent total loss of use of part of the body shall be treated as loss of such part.

(iii) 100 percent shall be the maximum percentage of compensation payable for permanent disability resulting from an accident or series of accidents arising from one cause in respect of any one such person.