

Head Office:

Plot 1 Bombo Road | P.O. Box 9393, Kampala, Uganda
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PERSONAL ACCIDENT CLAIM FORM

To be completed by the Insured and his doctor and returned within seven days of its receipt by the Insured

INSURED / CLAIMANT DETAILS

1. Name and Address in full of the Insured

2. (a) Name of the claimant

2. (b) Age next birthday

2. (c) Present profession or occupation/designation

ACCIDENT DETAILS

3. (a) When did the accident occur?

3. (b) Where did the accident occur?

3. (c) State how it happened (Full description to be given)

3. (d) Name and address of any witness of the accident

3. (e) Name and address of the doctor who first attended to your injuries

3. (f) Name and address of your usual Medical Attendant

ADDITIONAL INFORMATION

4. (a) Have you been able to attend any part of your normal occupation since the accident?

☐ Yes

☐ No

4. (b) If so, from what date?

5. Have you required medical or surgical treatment during the past five years?

☐ Yes

☐ No

If so give particulars

6. Are you claiming under any other insurance?

☐ Yes

☐ No

If so give particulars

I hereby declare that the foregoing particulars are true in every respect.

Date

Signature

MEDICAL REPORT

Any claim must be supported by a report from the Insured's medical Attendant, any fee for the report being payable by the Insured.

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PERSONAL ACCIDENT CLAIM FORM

Medical Report - to be completed by the Medical Attendant (Any fee for this report is payable by the patient)

MEDICAL REPORT

1. Name of patient	
2. What injuries has the patient sustained?	
3. Where were you first consulted in connection with this Accident?	
4. Are you the patient's usual Medical Attendant? If so, how long have you known him?	
5. Is the patient suffering from any injury or disease irrespective of that stated above? If so, please state the nature of the same and to what extent recovery may be affected thereby.	
6 (a) (i). Is the patient entirely prevented from following his usual occupations?	
6 (a) (ii). If so, from what date did such incapacity commence?	
6 (b). How much longer do you consider such disablement will continue?	
6 (c). If the patient is capable of attending to part only of his usual occupation state from what date he was able to partially work and the amount of such duties he is able to perform?	
6 (d). How much longer do you consider such disablement will continue?	
6 (e). If the patient is able to perform his normal occupation please state the date from which he commenced	
7. General Remarks	

I certify that to the best of my belief the foregoing statements are correct.

Signature

Qualifications

Address

Date