



ZIMNAT LION
INSURANCE

ZIMNAT LION INSURANCE COMPANY LIMITED

PERSONAL ACCIDENT CLAIM FORM

Claim No.

The Insured is requested to state as fully and accurately as possible the information asked for below:-

Names Age

Address Height

Occupation Weight

Policy No. Date Premium paid

Date of accident Time Place

Full details of accident

Nature of injury

Names and addresses of witness of accident

Name and address of doctor attending you

Is he your usual medical attendant?

Extent of Disablement

Dates

How long have you been confined to bed? From to

How long have you been confined to your house? From to

How long have you been wholly prevented from attending to all administrative and superintending duties? From to

How long have you been prevented from attending to a substantial portion of your administrative and superintending duties? From to

Are you now wholly or partially prevented from attending to your administrative and superintending duties?

Do you hold any other accident insurance?

If so, state name of company and amount of insurance

Have you any suggestion to make for an immediate settlement?

If so, state amount you would be prepared to accept

I hereby declare that I am suffering from the accident above described and claim compensation under the above policy in respect thereof; I hereby warrant the truth of the foregoing particulars in every respect and declare that the conditions of my insurance have been fully complied with; and that I have not abstained from my usual occupation longer than absolutely necessary; and I agree that if I have made or shall in any further declaration the directors may require of me in respect of the said accident, make any false or untrue settlement; suppression or concealment, the policy shall be void, and my right to compensation absolutely forfeited.

Signature Witness

Date

CERTIFICATE OF MEDICAL ATTENDANT

(To be furnished at the insured's expense)

THE MEDICAL ATTENDANT OF THE CLAIMANT SHOULD READ THE NOTICE BELOW BEFORE FILLING UP THIS FORM

Name of claimant

Address

Occupation Age

Nature and cause of injury

If to eye or limb, state right or left

Whether the appearance of the injury is consistent with the account given of the accident

Date on which you first attended claimant for this injury

Has claimant been wholly prevented from attending to any portion of his business; if so, how long?

Is claimant suffering from any disease or illness apart from his injury, and is there any illness or circumstances which may tend to retard recovery? If so, give particulars

Between what dates do you consider:-

Total disablement will last

** Partial disablement will last

Present condition

Remarks

I hereby certify that the above-mentioned met with the accident referred to, the injuries he is suffering from are solely the result of the said accident, and that the foregoing statements are correct.

Signature Address

Qualifications Date

* Temporary total disablement is described in the policy as such injury as shall disable and absolutely incapacitate the Insured from attending to any administrative and superintending duties.

** Temporary partial disablement is described in the policy as such injury as shall disable the Insured from attending to a substantial portion of his administrative and superintending duties.