

Personal Accident Claim Form (part II a)

CERTIFICATE OF MEDICAL ATTENDANT [To be given at the Claimant's Expense]

QUESTIONS TO BE ANSWERED BY MEDICAL ATTENDANT

<p>1. Name of Patient</p> <p>2. Profession or Occupation</p>	<p>1.</p>
<p>Are you the Patient's usual Doctor?</p>	<p>2. Period known to you?</p>
<p>3. (a) Date of the accident (b) When did you first see him after the Accident? © Where did you then see him?</p>	<p>3. (a)</p> <p>(b) Date Time am pm</p> <p>©</p>
<p>4. (a) Is he of sober and temperate habits? (b) Was he, in your opinion, perfectly sober at the time of the accident?</p>	<p>4. (a)</p> <p>(b)</p>
<p>5. (a) State as fully as possible the exact nature and extent of the injuries and which side is affected (Block Capitals please) (b) Brief description of the accident. © State whether the injuries and their present condition are sufficiently accounted for by the above description.</p>	<p>5. (a)</p> <p>(b)</p> <p>©</p>
<p>6. (a) Is the Patient now, or was he at the time of the accident suffering from or affected by any physical infirmity, disease or illness, irrespective of the injuries? (b) If so, state nature thereof and to what extent the recovery of the Patient may be affected thereby. © Is he suffering, or has he suffered from any cardiac affection, gout, rheumatism or fit of any kind? (d) Dates and details of any other injuries or illnesses from which he has suffered.</p>	<p>6 (a)</p> <p>(b)</p> <p>©</p> <p>(d)</p>

Personal Accident Claim Form (part II a)

7. Are you aware of anything in the previous medical history of the Patient which might have contributed directly or indirectly, to the occurrence of the accident, of which may be likely in any way to retard his recovery from it?

[Empty box for answer to question 7]

8. State the present condition of the Patient.

[Empty box for answer to question 8]

9. (a) Has the Patient been totally unable to attend to business of any kind?
(b) If so, from what date? him after the accident?
(c) If such total disability is continuing, upon what date do you consider he should be able to resume any part of his duties.
(d) From what date has the Patient been able to attend to part of his business >
(e) If partial disability is continuing upon what date do you consider he should be able to resume his normal duties?
(f) If the Patient has now recovered, date of recovery.

9. (a)
(b)
(c)
(d)
(e)
(f)

[Empty box for answer to question 9]

10. (a) General Remarks

[Empty box for general remarks]

[Empty box for general remarks]

I hereby certify that, having personally examined the above-mentioned patient, I am of opinion that the injuries he is suffering from are solely the result of the said accident and that I am of opinion there are no other circumstances tending to produce either total or partial disability.

Signed..... Qualifications:

Address: Date:

N.B: The Claimant is not totally disabled within the meaning of the Policy when he is capable of attending to ANY PART of his usual business or occupation

Personal Accident Claim Form

Liability is not admitted by the issue of this Form, which must be COMPLETED and returned WITHIN SEVEN DAYS OF RECEIPT, in the Office of the Company from which the Policy was sent.

1. Name of patient

2. Date of birth

19.....

Weight	Kilogrammes	Pounds
Height	Metres	Feet

2. Private Address

3. Present profession or occupation
business address
if more than one, state all.

if an employee, give name, address and business of employer.

4. Policy number

membership number, if any.

5. (a) When did the accident occur?

(a) DateTimea.m/p.m

(b) Where did it happen?

(b)

(c) What was the claimant doing at the time?

©

(d) Description of accident

(d)

(e) Nature and extent of injuries-if to eye, arm or leg state whether right or left.

(f) Is claimant right or left-handed?

6. (a) Name and address of doctor who first attended claimant after the accident

(a)

(B) Name and address of usual medical attendant.

(B)

Personal Accident Claim Form (part 2)

7. Names and addresses of witnesses of the accident

8. (a) Has claimant ever been, or
(b) is he at present insured in respect of personal accident risks?
(c) If so, with whom (including Friendly Societies or Benefit Societies.
(d) Has claimant ever made a claim or received any payment under such Insurances? If so, please state amount or amounts and approximate dates
(e) Has Claimant ever made a claim on or received any payment from this Company? If so, state amount or amounts, and when.

(a)
(b)
(c)
(d)
(e)

9. (a) As a result of the accident has Claimant been totally disabled or incapacitated from attending in any way to his usual business or occupation or to business of any kind?
(b) If so, from what date?

(a)
(B)

10. (a) Has he been able to attend to some portion of his usual business or occupation?
(b) If so, from what date?

(a)
(B)

11 (a) Is he at the present time totally disabled as above?
(b) If so, when does he anticipate being able to resume at least part of his usual business Or occupation?

(a)
(b)

Personal Accident Claim Form (part 3)

- 12. (a) Is he at the present time totally disabled as Above?
- (b) If so, when does he anticipate being able to resume his usual business or occupation?

(a)

(b)

13. From what other injuries or illnesses has Claimant suffered and when?

- 14. (a) If immediate settlement is preferred, state amount acceptable in full settlement of this claim

(Compensation is not payable weekly but in one sum at termination of disablement. The Company, however, is always willing to consider any proposal the insured cares to make for an immediate and final settlement).

I hereby declare that I am the person referred to in the above particulars and that all the above statements are true and complete and that I was perfectly sober at the time of the accident.

Date..... Signature of Claimant.....

N.B:- If this form has to be filled in and signed on behalf of the Claimant, the relationship to the Claimant of the Signatory should be stated here

THE LION OF AFRICA INSURANCE COMPANY LIMITED