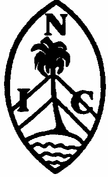

NATIONAL INSURANCE CORPORATION OF TANZANIA LTD.

P.O. Box 9264, Tel: 113823/9 Dar es Salaam Tanzania

MSAFIRI (TRAVEL) ACCIDENT CLAIM FORM

Claim No .... **Policy No. ....**

(To be completed by the Insured and his Doctor)

1. (a) Name of Insured (b) Name of the Injured person in full	....
2. (a) Age next birthday (b) Present profession or occupation	....
3. Present address	....
4. (a) when and where did the accident occur? (b) State the route of your journey © Give particulars of conveyance (car, Bus Marine, rail, air indicating flight No. or car Reg No etc.) (d) How did it happen (full description to be given) (e) Name and addresses of any two witness of the accident	Date .... Time .... Place .... From .... To ....
5. (a) Name and address of a Doctor who attended you immediately after the accident (b) Name and address of a Doctor now attending you. (c) State nature of incapacity (d) Did the incapacity commence from the date of the accident? (e) If not when did it commence?	....
6. Are you entitled to compensation from any other company or any club in respect of the injury for which you are claiming. If so full particulars of that Company or club be given.	
2. Where can a medical or other officer of the Corporation visit you if necessary.	
3. Have you incurred loss or damage to your luggage resulting from this accident? Give particulars and value. of your luggage.	

NOTE:- Any claim must be supported by a report from the Insured's Medical attendant on the reverse side of this form. Any fee for the report is payable by the Insured.

DECLARATION

I, the undersigned, hereby declare that I am the person referred to in the above statements, which are true in every respect and made without reservation and I hereby claim to be paid.

(a) Compensation at the rate of .... per week, as from the ....
.... Or

(b) The total sum of .... which I agree to accept in settlement of may claim

Signature and rubber stamp of the insured ....

Date .... Signature of the injured person ....

Delete (b) if total claim can not now be made, or (a) if total claim can be made.

PART B. MEDICAL REPORT

(To be filled in by a qualified Doctor and any fee for this report is payable by the patient).

1. Full name of patient: ………

2. Describe fully the cause and circumstances of the accident as stated to you: ……………………………………………

   ………

3. Are the nature of injuries or cause of death consistent with or directly attributable to the accident as stated to you? Please give details ……………………………………………………………………………

   ………

   ………

4. In case of injuries, recommend a percentage commensurate with the incapacity sustained by the Insured person ……………….. (%) Give reasons for supporting your recommendation: ………………………………

   ………

   ………

5. Where the insured person has died, please describe the immediate and sufficient cause of his/her Death ………

   ………

   ………

6. General Remarks: ………

   ………

   ………

   ………

   ………

7. If the Patient on your advice shall be (a) Confined to bed or (b) Confined to house, state Probable duration of such Confinement from this date. OR (c) Able to get out of doors?	(a) ……………… From ……………… to ………….. (b) ……………… From …………………to …………… (C) ……………… From …………………to …………..
8. If the Patient is in your opinion Unable to give partial attention to his Profession or occupation please state:- (a) Date of commencement of partial Disablement (b) Probable duration of same disablement	(a) (b)
9. If disability has terminated please State date of termination.	

DECLARATION:

I hereby declare to the best of my knowledge and belief that the foregoing statements are true: Signature ……………………………

Full name and address of Doctor: ………………………………………………………………………………………

Qualification: ……………………………………………………………… Date: ………………………………………………