

Policy No.

Claim No.

Period of cover



NATIONAL INSURANCE CORPORATION OF TANZANIA LTD.

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(INCORPORATED IN TANZANIA)

PERSONAL ACCIDENT CLAIM FORM

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

1.	(a)	Name of the insured	_____
	(b)	Name of the injured 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)	How did it happen? (Full description to be given)	_____
	(c)	Names and addresses of any witnesses of the accident	_____
	(d)	Name and address of Doctor who attended you immediately after the accident.	_____
	(e)	Name and address of Doctor now attending you.	_____
5.	(a)	Did the incapacity commence from the date of the accident?	_____
	(b)	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 to be given.		_____
7.	Where can a medical or other officer of the Corporation visit you if necessary?		_____

Medical report. Any claim must be supported by a report on the reverse side of this form from the insured's Medical Attendant, any fee for the report being 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.

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

- (a) Compensation at the rate of per week, as from the
- (b) The total sum of Which I agree to accept in settlement of my claim.

Signature and rubber stamp of the Insured

Date

Signature of the injured person

MEDICAL REPORT

(Any fee for this report is payable by the Patient)

Name of patient	
1. Describe fully the cause and circumstances of the accident as stated to you.	
2. Are the appearance of the injuries consistent therewith and do you believe they were caused as stated.	
3. Nature of injury – please give detailed particular.	
4. On what date did the patient first consult you in connection with this accident?	
5. Are you the patient’s usual Medical attendant? If so, how long have you know him?	
6. Is the patient suffering from any injury or disease irrespective of that stated above? If so, please state nature of the same and to what extent recovery may be affected thereby.	
7. If the patient on your advice: - (a) Confined to bed? (b) Confined to house? If so, state probable duration of such confinement from this date. (c) Able to get out to 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 from this date.	(a) (b)
9. If the patient is in your opinion able to give partial attention to his profession or occupation, please state: - (a) Date of commencement of partial disablement. (b) Probable duration from this date.	(a) (b)
10. If disability has terminated, please state date of termination.	
11. General remarks

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

Signature

Qualifications

Address

Date