RELIANCE INSURANCE COMPANY (TANZANIA) LIMITED

P.O. BOX 9826, DAR ES SALAAM

PERSONAL ACCIDENT CLAIM FORM

"To avoid delay and unnecessary correspondence in the processing of your claim pleased observe the following requirements:

1. Ensure that both the claim form and the medical certificate are properly completed
2. Supporting documents or copies thereof plus original medical bills incurred if any. Must be submitted with the claim form.

Claimant's name (in full) _____

Address _____

Present Occupation _____Present Age _____

Policy No. _____Date of payment of last premium _____

1.	(a)	Date of Accident?	1.	(a)	Date Time
	(b)	Where did it occur?		(b)	
	(c)	Describe fully how it happened		(c)	
	(d)	Give name, occupation and address of a witness of the accident		(d)	Name Occupation Address
2.	(a)	Describe the names and extent of the inuries you have received	2	(a)	
	(b)	Give names and addresses of the Doctors who have attended you for these injuries		(b)	Names: Address:
3.	(a)	State the number of days you have been ENTIRELY confined to your Bed/Room or House	3	(a)	To Bed for ___ days from _____ to ____ To Room for ____ days from ____ to _____ To House _____ days from _____ to _____
	(b)	If you are still confined toy our bed or Room or House state which		(b)	_____
4.	(a)	State the extent and duration of your Inability to attend to oyur business or occupation	4.	(a)	I have been disabled PARTIALLY for ____ days from _____ to ____ WHOLLY for _____ days from _____ to ____ I am now _____ disabled (Insert "wholly" partially" or "not at all")
	(b)	If still disabled state how much longer the disability is likely to continue		(b)	_____

5.	Have you since the accident personally directed or supervised or given any attention whatever to any part of your business or occupation? If so give full particulars and dates	5	
6.	(a) Are you entitled to receive compensation from any other company or other source? If so, give full particulars.	6.	(a)
	(b) Have you ever claimed compensation from any company? If so, give full particulars		(b)
7.	Are you perfectly free from any Physical Defect, Infirmity or Disease?	7.	
8.	Are you at the present time able to state the amount for which you are willing to settle the claim? (The compensation is based upon the actual period of disablement)	8.	

DECLARATION

I, the undersigned, hereby declare that I am the person referred to in the above statement, which is true in every respect, and made without reservation.

I hereby authorise the company to apply to my Medical Attendant mentioned above, for a Report to be furnished at my expense in the form used by the Company for the purpose.

Date _____ Signed _____

NOTE: The medical Certificate must be completed by your doctor before this Claim Form is forwarded to the Company

MEDICAL CERTIFICATE

I order to establish this claim, the Claimant must obtain and forward to the company a certificate from a duly qualified and registered Medical Practitioner, and it is essential that this form be filled up a minutely as possible so that the Medical Officer of the Company may properly understand the nature of the case

The Medical Attendant of the Claimant is required to state:-

1. The name and Occupation of the Claimant:

2. The exact nature and extent of the injuries caused by the accident. If a Hand or an Arm a Foot, or a Leg. State whether it is RIGHT or LEFT.

Regions Injured	**Nature and extent of**
3. Whether the claimant has suffered or is now suffering from any constitutional or local disease or Physical infirmity. If so state the nature of such disease or infirmity and to what extent it affects the disablement	3.
4 (a) When and where he first attended the Claimant?	4. (a) Date _____ Time _____ (b) On the _____ day of _____

5. To what extent the above accidental injuries have necessarily disabled the Claimant from giving attention to business	Claimant has been disabled TOTALLY For ____ days PARTIALLY for _____ days	Claimant is now * _____ disabled. * Insert totally, partially or not at all as the case may be	The further disability (if any) will in my opinion continue For _____ entirely For _____ partially From the present time.

Total disablement arises when the Claimant is rendered completely incapable of attending to any part of his ordinary professions, business or occupation. Partial Disablement arises when the Claimant is a little inured, or has so far recovered from injuries as to be capable of attending to some portion o f his ordinary profession, business or occupation

6	(a) If the Claimant is now, in any way, attending to business, on what day he first commended doing so after the accident (b) If not whether you consider claimant fit personally or supervise or direct his Business or occupation	6 (a) (b)
7	Have you any reason to thin that the patient was not perfectly sober at the time of the accident?	7
8	If there any information, professional or otherwise that you consider should be known to the company	8

REMARKS: If any:

I certify that I have satisfied myself by personal examination that the Claimant has sustained an accident causing injuries as above described.

Signature: _____ Qualifications_____

Date: _____ Address: _____

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