CIC GENERAL INSURANCE UGANDA LTD

GROUP PERSONAL ACCIDENT/ WORKER'S COMPENSATION CLAIM FORM

CIC INSURANCE

IMPORTANT NOTICE:

1. The issuance of this claim form shall not be construed or taken as an admission of liability on the part of the Insurer.
2. All questions must be answered fully, accurately, and with comprehensive elaboration where required.
3. No claim can be admitted unless the Medical Certificate overleaf be furnished at the expense of the Claimant.

1. THE CLAIMANT

Name of Insured _____ Policy Number _____

Telephone No: _____ Occupation _____

Email Address _____ Correspondence Address _____

Agency _____

2. PERSONAL DETAILS

Present Age _____ Height (meters & cm) / Weight (kgs) _____

3. ACCIDENT DETAILS

i. When did the accident occur? (State time and date) _____

ii. Give full particulars of where the accident occurred, how it happened, cause and injuries sustained.

_____

_____

_____

_____

iii. Give names and addresses of any witnesses of the accident

_____

_____

_____

_____

_____

_____

4. MEDICAL DETAILS

i. Give the name and address of your ordinary medical doctor

ii. State where and when a medical doctor or representative of the company can visit you if necessary

iii. State the period during which you have been totally disabled and prevented from attending to your business as the sole and direct result of the accident

iv. Are you still totally disabled? If not, from what date were you able to attend to some part of your business?

5. OTHER INSURANCE

i. Have you previously claimed or received compensation under an Accident and/or Sickness Policy?
If so, please give particulars

ii. Are you insured elsewhere?
If so, give the name of each company or Insurer, and the amount you are entitled to claim

DECLARATION

I/We hereby declare that the whole of the statements made by me/us in this claim form are in every respect true, and I/We agree that if I/We have made any false or untrue statement(s), or if there be any suppression or concealment of any material fact, my/our right to recover under the policy shall be absolutely forfeited.

Date: Signed by policy holder:

CIC GENERAL INSURANCE UGANDA LTD

Block A, Plot 7-11 Buganda Road, Next to Buganda Road Magistrate's Court. P.o Box 34975, Kampala, Uganda

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UGANDA | KENYA | SOUTH SUDAN | MALAWI

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PRIVATE AND CONFIDENTIAL

MEDICAL CERTIFICATE (TO BE COMPLETED BY THE INSURED'S DOCTOR)

I certify that (Patient's name) _____

Has consulted me for _____ The patient was injured on _____

If the patient's condition is complicated by any other disease or infirmity, please give details

_____

_____

_____

Is the present complaint likely to recur? _____

The patient is permanently and totally or partially disabled and is expected to remain so until:

_____

Please state the percentage of permanent incapacity, if any _____

Any comments or information deemed necessary

_____

_____

_____

DECLARATION

I/We hereby declare that the whole of the statements made by me/us in this medical certificate are in every respect true, and I/We agree that if I/We have made any false or untrue statement(s), or if there be any suppression or concealment of any material fact, the claimant's right to recover under the policy shall be absolutely forfeited.

Date: _____ Signed by policy holder: _____

ANY ADDITIONAL NOTES:

_____

_____

_____

_____

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