NATIONAL INSURANCE COMPANY LIMITED
PERSONAL ACCIDENT CLAIM FORM

(If the Insured is unable to complete this form, it may be filled up on his behalf.)

The Insurers do not admit liability by issuing this form

Name of Insured : _____ Age : _____

Name of Life Insured : _____ Age : _____

Address in full : _____

_____

_____

Profession or Occupation : _____

(Please indicate whether Master Superintending, Master working or Workman)

Policy No: _____ Renewal : _____ Claim No: _____

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1. State when and where the accident took place Give date and hour. :

2. State how it happened and what the insured/the Life Insured was doing at the time. :

3. State as fully as you can the nature and extent of the injuries sustained. :

4. Give the name and address of the Doctor attending the Insured/the Life Insured for these injuries. :

    - Is he the usual Medical Attendant? :
    - Has any other Medical man been consulted :

5. If the Insured/the Life Insured is still disabled, please indicate when he/she is likely to be fit to resume usual business or occupation-either wholly or in part. :

6. When and where can the Insured/the Life Insured be visited (if necessary) by a Medical Officer or an Official of the Insurers? :

7. Was the Insured/Life Insured in good health and free from physical defect or infirmity at the time of the accident? :

8. When did he/she last receive medical attention previous to the above mentioned accident ? Please state nature of complaint. :

9. Is a claim being made under any other Insurance? If so please give particulars. :

10. If an immediate settlement is acceptable, please state the amount. :

DECLARATION

I, the undersigned, do hereby declare that to the best of my knowledge and belief the foregoing particulars are true and correct.

Signature of the Employee/Nominee

Date :

Signature of the Officer-in-charge
(With Office Seal)

Date :