KENINDIA

KENINDIA ASSURANCE COMPANY LIMITED

Incorporated in Kenya

Head Office
P.O. Box 44372
NAIROBI Kenya

PERSONAL ACCIDENT CLAIM FORM

Policy No. P.A.................................

Claim No.......................................

Important Notice :—The Issue of this form is not to be taken as an admission of liability.

FORM TO BE COMPLETED BY THE INSURED.

1. (a) Name of Insured (in full) ______
   (b) Address in full ______
   (c) Profession or occupation ______ (d) Age last birthday ______
2. (a) No. of Policy ______ (b) Date of Policy ______ (c) Date of last payment of premium ______
3. (a) Date and time when accident occurred On the ______ day of ______ (date) (month) ______ 19 ______ at ______ O'clock in the ______
   (b) Where it happened ______
   (c) Name and address of Witness ______
4. How did the accident occur ? ______
5. Nature of injury received : ______
   (if to limb or eye, state whether right or left) ______
6. (a) Nature of disablement ______
   (b) Extent of disablement ______
   Confined to house from ______ to ______ Partial disablement from ______ to ______
   (c) Present state of incapacity ______
7. Name and Address of Surgeon or Doctor in attendance ______
8. (a) Where and when can a Medical Officer of the Company visit you if necessary ? ______
   (b) Name of nearest Railway Station and distance therefrom ______
9. (a) Are you insured in any other Office or Offices granting compensation for accident ? ______
   (b) If so state name and address of Company or Companies and amount of insurance. ______
10. If you are claiming for Temporary Total Disablement, does your weekly income immediately before the accident exceed by 50% the total weekly compensation you will receive now from this and all other sources ? ______

I hereby declare that the foregoing statements are made by myself and are true in all respects and that I have not attempted to conceal from the Company anything with which it ought to be made acquainted, and also that I have not abstained from my usual occupation longer than is absolutely necessary; and I agree that if I have made, or, in any further declaration the Company may require, shall make any false or fraudulent statement or any suppression, concealment or untrue averment whatever, the Policy shall be void, and my right to compensation absolutely forfeited; and I am willing, if required, to make a Statutory Declaration before a Justice of the Peace of the truth of the whole of the foregoing statement or any other statement I make make in connection with this claim.

Signature of Claimant ______

Date : ______

Witness : ______

Address : ______

CERTIFICATE TO BE FILLED UP AND SIGNED BY AN EYE WITNESS OF THE ACCIDENT

I hereby certify that I was present when the Accident occurred to Mr. ______ on the ______ day of ______ 19 ______ in the manner stated by him overleaf, that it *was caused by / was not caused by ______ his wilful act, and that he was not under the influence of intoxicating liquor at the time.

Signature ______

Name ______

Address ______

Occupation ______

Date ______

* Strike out which is not applicable.