



INTRA AFRICA ASSURANCE COMPANY LIMITED

(Incorporated in Kenya)

HEAD OFFICE

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BRANCH OFFICE

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PERSONAL ACCIDENT CLAIM FORM .

This form is issued without admission of liability, and must be completed and returned within seven days after its receipt. No claim can be admitted unless a medical certificate overleaf be furnished at the expense of the claimant.

Agency name: _____

1. SECTION 1: BUSINESS DETAILS

A. Full name of claimant _____

B. Pin number(please attach copy): _____

C. Certificate of Registration/Incorporation/ID/Passport
(Please Attach copy) _____

D. Contact Details:

Mobile: _____ Email: _____

Postal: _____ Code: _____ Town/City: _____

Web: _____ Fax: _____ Tel: _____

Occupation: _____ Age: _____

2. A). When did the accident occur? State day, date and hour. _____

B). Where did it occur? _____

C). Give full particulars of the cause and the injuries sustained _____

3. Give names and addresses of any witnesses of the accident _____

4. A). Give name and address of the Doctor who attended you. _____

B). Name and address of your ordinary medical attendant _____

5. State where and when a Medical or other Officer of the Company can visit you, if necessary.

6. A). State the number of days you have been necessarily and entirely confined to Bed, Room or House, as the sole and direct result of the injuries sustained. **NB: BOTH DATES ARE INCLUSIVE.**

Place	No of Days	From (Date)	To (Date)
Bed			
Room			
House			

B). If still confined to any, state which: _____

C). Have you in any way attended to business or work during the above period? _____

7. Have you previously claimed or received compensation under an Accident and/or Sickness policy?

8. Are you insured elsewhere?

If so, give name of each Company or Insurer and amount you are entitled to claim. _____

Declaration.

I hereby declare that I have received the injuries above described, and warrant the truth of the foregoing particulars in every respect, and agree that if I have made, or if, shall make any false or untrue statement, suppression or concealment, my right to compensation shall be absolutely fortified.

I claim to be paid the sum of Kshs: _____ per week, or the total sum of Kshs: _____

which I agree to accept in full settlement of my claim on the company.

Signature: _____ Date: _____