GALLOWAY'S
INSURANCE CONSULTANCY AGENCIES

PERSONAL ACCIDENT CLAIM FORM

(All questions in this form must be answered in block letters and in the claimant's own handwriting or to his dictation)

AGENCY:

TELEPHONE:

E-MAIL:

POLICY NUMBER:

Ensure that both the Claim Form and the Medical Certificate are properly completed. Supporting documents or copies thereof plus original medical bills incurred, if any, must be submitted with the Claim Form.

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1. Insured's Name:

2. Claimant's Name:

3. Postal Address:

Postal Code:

4. Main Telephone No:

Alternative Telephone No:

5. Email:

6. Occupation:

7. Date of Birth:

8. Date of Payment of Last Premium:

9. Date of Accident:

10. Place Accident Occurred:

11. Describe fully how the accident happened:

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12. Witness of the Accident

- **Name:**
- **Address:**
- **Occupation:**
- **Telephone No.:**

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13. Nature and extent of injuries (attach medical report if available):

14. Names and addresses of doctors/hospitals who attended you:

15. State the number of days you have been confined:

- To bed: ___ days (from ___ to ___)
- To house: ___ days (from ___ to ___)

16. If still confined, state where:

17. State the extent and duration of your inability to attend to your business or occupation:

- Partially disabled: ___ days (from ___ to ___)

- Wholly disabled: ___ days (from ___ to ___)

I am now: ☐ Wholly Disabled ☐ Partially Disabled

18. If still disabled, how much longer is it likely to continue?

19. Since the accident, have you personally directed, supervised, or attended to any part of your business/occupation? If so, give particulars:

20. Are you entitled to compensation from any other company or source in respect of the accident? If yes, give details:

21. Have you ever claimed compensation before from any other company for previous injuries? If yes, give details:

22. Monthly earnings for the month prior to the accident: Ksh. _____

DECLARATION

I, the undersigned, declare that the above statement is true in every respect, made without reservation. I hereby authorize **Galloways** to apply to any medical attendant mentioned above, for a report to be furnished at my expense.

Date: _____

Signature of Insured: _____

(If the insured is a Company, a stamp should be placed over the signature)

MEDICAL CERTIFICATE

(To be completed by a qualified and registered Medical Practitioner)

1. Name of Claimant in full:
2. Occupation of Claimant:
3. Exact nature and extent of injuries (state the part injured – arm, foot, leg, etc.):
    - Part injured:
    - Right / Left:
    - Nature and extent:
4. Any pre-existing disease or infirmity? If yes, give details:
5. When first attended?
6. Where first attended?
7. Are you still attending the claimant? If yes, explain:
8. Extent to which accident injuries disabled claimant from attending to business/occupation:
    - Partially: ___ days (from ___ to ___)
    - Wholly: ___ days (from ___ to ___)
    - Claimant is now: ☐ Wholly disabled ☐ Partially disabled ☐ Not disabled
    - Expected further disability: ___
9. If claimant resumed business, date of resumption:
10. If not resumed, is claimant fit to perform occupation?
11. Was intoxicating liquor and/or drugs consumed within 12 hours before accident? If yes, give details:
12. Additional remarks (if any):

Declaration by Medical Attendant:

I certify that I have examined the claimant and confirm the injuries described above.

Qualifications:

Address:

Date:

Signature of Medical Attendant: _____