



NICO GENERAL INSURANCE COMPANY LIMITED

NICO HOUSE, P.O. Box 2592, Blantyre, MALAWI

Tel: (265)01 822 699 Fax: (265)01 822 363

E Mail: nicogen@nicogeneral.com

FUNERAL INSURANCE CLAIM FORM

1. Details of the Policyholder

- i) Name -----
- ii) Address: -----
Tel. No.: -----
- iii) Policy No.: -----

2. Details of the Deceased Person

- i) Name: ----- Employee No. -----
- ii) Date of Birth: -----
- iii) Place of Death: ----- District: ----- Hospital : -----
- iv) Death Certificate No. -----
- v) Name of Doctor Certifying Death: -----

3. Details of Claim

Amount : -----

4. Declaration

I / We ----- declare that the foregoing particulars are true in every respect.

Signature on Behalf of the Insured

Name

Capacity

Date

NB



1. Claim settlement is within 48 Hours of receipt of this form by the Company.
2. The company reserves the right to call for any document which it may deem fit in dealing with this claim.

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CLAIMS SURVEY REQUEST FORM

SECTION A: (To be completed by Claims Department)

ASSESSOR:

Please assess the following loss and submit your report to this office. The loss and underwriting details are as follows:-

INSURED: SITUATE:

DATE OF ADVICE OF LOSS:	DATE OF LOSS:
CAUSE OF LOSS:	POLICY NO.:
PERIOD OF INSURANCE: FROM:	TO:
INSURED PERILS : F/L BD RSMD EXP EQ EQFS SC SP (----%) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
(Tick cover applicable)	
FULL DETAILS OF DAMAGE	PROPERTY INSURED
EXCESS / DEDUCTIBLE: K	
DATE OF COMPLETION:	
NAME OF CLAIMS STAFF	
SIGNATURE:	

SECTION B: (To be completed by Surveyor)

ESTIMATE OF LOSS

- (a) Buildings K
(b) Contents K

SITUATION OF LOSS:

Distance :
Type of access road :

(c) Tobacco Leaf K
(d) ----- K
(e) ----- K -----
TOTAL -----

Suitable Vehicle :

SECTION C: APPROVAL BY HEAD OFFICE

(a) SURVEY TO BE CARRIED OUT

i) Urgently

ii) Normal

iii) Not required

(b) TRANSPORT TO BE USED

i) Pool Vehicle

ii) Hired Vehicle

iii) Not required

SIGNATURE:

DATE:

MGZ/28/02/2003



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CLAIMS DECLARATION

CLAIM NO.: -----POLICY NO.:-----

Date of Loss: -----

I (full name in block letters) -----

of P.O. Box ----- hereby confirm the truth of the following statements which I have made so that my claim be dealt with expeditiously by the Nico General Insurance company Limited (herewith referred to as "the Company").

1. I suffered a -----at my house / shop / office
Situated Plot No. ----- at approximately -----
On -----
2. This occurrence was reported by -----
to ----- Police Station at -----
on ----- . The Officer to whom the matter was reported was -----
3. The items and value listed on the claim form submitted to the Company correspond to those which were reported as stolen to the police.
4. I understand that if any of the above statements is false I am guilty of attempting to defraud the Company and my claim may be invalidated in to.

Signed by me this -----day of -----200--

Signature: -----

Witness : -----

Address: -----

Occupation: -----



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PUBLIC LIABILITY CLAIM FORM

The issue of this form does not imply admission of liability on the part of this Company.

All questions must be answered fully – ticks and dashes are not acceptable.

Name of Insured :

Full Address:Telephone No.:

Business or Occupation:

Policy No.:

1. (a) When did the accident occur? (b) Where did the accident occur? (c) Explain fully how the accident happened.	(a) (b) (c)
2. Give names and addresses of witnesses (if any)	
3. (a) Was the accident reported to Police? (b) If yes, (i) Name the Police Station (ii) Give date reported (iii) Name the person who reported to Police.	(a) Yes / No (b) (i) (ii) (iii)
4. (a) Were persons injured? If yes, provide full details on page 2	(a) Yes / No
5. (a) Was any property damaged? If yes, provide full details on page 2	(a) Yes / No
6. (a) Have you received notice of a claim? (b) If yes, provide full details and attach to this form any correspondence received.	(a) Yes / No (b)
7. (a) Have you admitted liability? (b) Do you think you are legally liable? (c) If yes, give reasons why you are legally liable.	(a) Yes / No (b) Yes / No (c)

8. (a) Are there any other insurances covering this accident? (b) If yes, give name of Insurance Company	(a) Yes / No (b)
---	---------------------

DECLARATION

I / We hereby declare that the above information is in all respects true and correct.

SIGNATURE OF CLAIMANT: -----DATE: -----

A. DETAILS OF INJURED PERSONS

NAME	OCCUPATION	AGE	NATURE OF INJURY	FULL ADDRESS

B. DETAILS OF PROPERTY DAMAGED

QUANTITY	DESCRIPTION OF PROPERTY	EXTENT OF DAMAGE	ESTIMATED COST OF DAMAGE	OWNER'S NAME AND FULL ADDRESS



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FIDELITY GUARANTEE CLAIM FORM

The issue of this form does not imply admission of liability on the part of the Company.

All questions must be answered fully. Ticks and dashes are not acceptable.

Name of Insured:

Full Address :

Policy No.:

1. (a) When was the loss discovered?	(a)
2. Give the names of defaulting employees and their respective positions: (a) Name Position (b) Name Position (c) Name Position	(a) (b) (c)
3. (a) Have the Police been notified? (b) If Yes: (i) Name of Police Station (ii) Give date of notification (iii) Give name of person who notified the police	(a) Yes / No (b) (i) (ii) (iii)
4. State the period during which the default took place.	
5. What is the total amount of the loss.	K
6. (a) Give full details of how this amount has been calculated (see attached schedule) (b) Has the amount of loss been certified by Accounts or Auditors? If so, attach the Accountant's / Auditor's Report.	(a) (b)

<p>7. (a) Have the employees been involved in or been suspected of any previous loss?</p> <p>(b) If yes, give details</p>	<p>(a)</p> <p>(b)</p>
<p>8. Give full details of the circumstances of the loss and how it was discovered.</p>	
<p>9. What methods were used to conceal the defalcations?</p>	
<p>10. What steps have been taken to prevent recurrence?</p>	
<p>11. (a) have any other monies due to the defaulting employee been withheld.</p> <p>(b) If yes, provide details</p>	<p>(a) Yes / No</p> <p>(b) (i) Salary K-----</p> <p>(ii) Commission K-----</p> <p>(iii) Pension/ Gratuity K-----</p> <p>(iv) Leave Pay K-----</p> <p>(v) Other -----</p> <p>TOTAL = <u> </u></p>
<p>12. (a) Do you hold any other guarantee or security for the employee?</p> <p>(b) If yes, give details</p>	<p>(a) Yes / No</p> <p>(b)</p>

DECLARATION

I / We hereby claim the sum of K----- which was misappropriated and declare that the above statement is in all respects true and correct.

SIGANATURE OF CLAIMANT: -----**DATE:** -----

**SCHEDULE OF SUMS RECEIVED BUT NOT ACCOUNTED FOR
(ATTACHED TO FIDELITY GUARANTEE CLAIM FORM)**

DATE OF RECEIPT BY DEFAULTER	NAME AND ADDRESS OF CUSTOMR / FIRM FROM WHOM THE MONEY WAS DUE	AMOUNT



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GLASS CLAIM FORM (PLG.1) 200-4/72/MHP

THE ISSUE OF THIS FORM IS NOT AN ADMISSION OF LIABILITY ON THE PART OF THE COMPANY.

(Please answer all questions as fully as possible)

1.	Name of Insured:
2.	Address:-Tel. No.:.....
3.	Policy No.:
4.	Date of which breakage occurred
5.	Address of Premises where the breakage occurred.
6.	Nature of business carried on in such premises. If unoccupied, state since what date.
7.	Cause of breakage (state full particulars)
8.	Name and Address of person responsible (if any)
9.	Name and Address of any witness to the breakage.
10.	Have you made any claim in respect of Glass during the past 3 years? If so, please give full details.

PARTICULARS OF BROKEN GLASS:

DESCRIPTION OF GLASS BROKEN	WHETHER DOOR, WINDOW ETC.	SIZE OF BROKEN SQUARE	WHETHER CRACKED OR BROKEN OUT

I / We hereby declare that to the best of my / our knowledge and belief the foregoing statements and particulars are true and complete.

DATE: -----200-

SIGNATURE



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ALL RISKS CLAIM FORM (ALR.1) 200 – 4/72/ - MHP

THE ISSUE OF THIS FORM IS NOT AN ADMISSION OF LIABILITY ON THE PART OF COMPANY.

(Please answer all questions as fully as possible)

Name of Insured:	
Private Address:Tel. No.:	
Business Address:Tel. No.:	
Policy No.:	
1. Has the property been stolen, lost or damaged:	
2. When was the theft, loss or damage discovered and by who,? Please state date and time.	
3. State the circumstances under which the theft, loss or damage occurred.	
4. When and where was the property last seen by you?	
5. If the property has been stolen do you suspect anyone? If so whom?	
6. If the property has been lost or stolen give the date that the Police were informed and the name of the Police Station. (Note: It is essential that prompt notification of any theft or loss be given to the nearest Police Station.	

7. Are you the sole owner of the property? if not please give name of owner.	
8. If the property in question is not specifically Insured under the policy but forms part of a miscellaneous item please state the present value of all the property covered under the same item.	
9. Is the property covered under any other Insurance? If so please give full details.	
10. have you sustained any previous losses by fire or theft? Is so please give full details together with the name of any Insurance Company dealing with the loss.	

FULL INFORMATION REGARDING THE LOSS OR STOLEN ARTICLES MUST BE FURNISHED OVERLEAF.

I hereby warrant the truth of the above statements and of the information shown in the statement of claim.

DATE:-----

SIGNATURE OF INSURED



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LIVESTOCK CLAIM FORM

THE ISSUE OF THIS FORM DOES NOT IMPLY AN ADMISSION OF LIABILITY ON THE PART OF THE COMPANY

(Please answer all questions as fully as possible)

1.	Name of Insured:	
2.	Address:	Tel. No.:.....
3.	Policy No.:	
4.	Description of the animal for which this claim is made: (a) Sex (b) Name of animal (c) Breed (d) Colour and distinguishing marks or brands (e) Age (f) Value prior to illness	(a) (b) (c) (d) (e) (f)
5.	Information as to attention given to the animal: (a) When was animal first seen ill? (b) When was notice of this first sent to the veterinary surgeon? (c) When did the veterinary surgeon first see the animal? (d) Give dates of subsequent attendance of veterinary surgeon (e) When last seen by him	(a) (b) (c) (d) (e)
6.	Date of death	Hour Place (address)
	Page 2	

7. Cause of death:
- (a) If from accident, give full details (a)
And who was in charge.
 - (b) If from disease, give your opinion (b)
as to the cause.
 - (c) If from operation, give details (c)
-

8. Purpose for which used or employed.
When last at work.

9. If bought state:
- (a) From whom (a)
 - (b) Date of purchase (b)
 - (c) Price paid (c)
-

10. Amount of claim K-----
Amount received for salvage (enclose
Salvage voucher)

11. Is the animal insured elsewhere
If so give details.

12. If claim is for loss of in-foal mare, or foal,
Or in-calf cow give :
- (1) Date due to foal or calve (1)
 - (2) Actual date of foaling or calving (2)
-

13. How many:
- (a) Mares-in-foal or cows-in-calf have (a)
you had this season?
 - (b) Have you had insured this season (b)
 - (c) Have you lost this season (c)
-

14. If you own other animals of this same type
And class give particulars with ages and
Values.

DECLARATION

I hereby declare the foregoing particulars to be true, that I have withheld no important information,
and that proper treatment, attention and care were given to the above animal.

DATE: -----**SIGNATURE OF CLAIMANT:** -----



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MEDICAL CERTIFICATE (P.D.)

Name of Employer:

Name of Claimant:

<p>1. (a) Are you the usual medical attendant of the claimant?</p> <p>(b) What was the date of your first attendance for the present injuries?</p> <p>(c) Are you still in attendance?</p>	<p>(a)</p> <p>(b)</p> <p>(c)</p>
<p>2. State the cause of the accident as known by you</p>	
<p>3. Give details of the treatment claimant has undergone or is undergoing.</p>	
<p>4. Give particulars of the injuries sustained:</p> <p>(a) Regions injured</p> <p>(b) Nature and extent of the injuries</p> <p>(c) Are the symptoms due to the accident alone or are they traceable to any other cause.</p>	<p>(a)</p> <p>(b)</p> <p>(c)</p>
<p>5. Is the claimant now, or was he at the time of the of the accident, subject to, or suffering from, any illness or disease? If so, please state its nature and to what extent his recovery may be affected by it.</p>	

<p>6. Is the claimant permanently disabled? If the answer is Yes:</p> <p>If totally disabled state the percentage of incapacity suffered.</p> <p>(a) Describe fully, the nature of the Disablement,</p> <p>(b) Does the disablement exist now?</p> <p>(c) How does the disablement impair the claimants normal activities?</p> <p>(d) Is the disablement of a permanent nature or is it likely to improve with time?</p> <p>(e) Describe fully your prognosis:</p> <p>(i) for the twelve months immediately following the accident.</p> <p>(ii) Thereafter</p>	<p>Yes or No. ----- Totally or Partially -----</p> <p>Percentage -----</p> <p>(a)</p> <p>(b)</p> <p>(c)</p> <p>(d)</p> <p>(e) (i)</p> <p>(ii)</p>
--	---

Use the reverse of this form if further space is required

Signature: ----- Qualifications: -----

Name: -----

Address: ----- Date: -----



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SCHEDULE OF DISABLEMENT – BENEFIT 2

The Compensation hereunder is payable in the following proportions of the Basic Amount in the event of Permanent Disablement.

		<u>Compensation</u>
(a)	Loss by physical separation at or above the wrist or ankle of one or More limbs: -----	100%
(b)	Loss of whole eye -----	100%
	Sight of eye -----	100%
(c)	Injuries resulting in Permanent Total Disablement from following usual Occupation or any other occupation for which the Insured Person is fitted By knowledge or training: -----	100%
(d)	Loss of Four fingers -----	70%
(e)	Loss of thumb – both phalanges -----	25%
	- One phalanx -----	10%
(f)	Loss of index finger - Three phalanges -----	10%
	- Two phalanx -----	8%
	- One Phalanx -----	4%
(g)	Loss of middle finger - Three phalanges -----	6%
	- Two phalanx -----	4%
	- One phalanx -----	2%
(h)	Loss of ring finger - Three phalanges -----	5%
	- Two phalanx -----	4%
	- One phalanx -----	2%
(i)	Loss of little finger - Three phalanges -----	4%
	- Two phalanx -----	3%
	- One phalanx -----	2%
(j)	Loss of metacarpals - First or second (additional) -----	3%
	- (Third, fourth or fifth (additional) -----	2%

Compensation

(k)	Loss of toes	- all on one foot -----	30%
		- great, both phalanges -----	5%
		- great, one phalanx-----	2%
		- other than great, if more than one toe lost, each-----	1%
(l)	Loss of hearing -	both ears -----	80%
		one ear -----	25%
(m)	Loss of	- sight, except perceptions of light -----	75%
		- lens of eye -----	75%

PROVIDED ALWAYS THAT:

- (i) In the event of Compensation becoming payable under more than one of Benefits 2 (a) to 2(m) in respect of one Insured Person the total amount payable shall not exceed 100% of the Basic Amount in respect of such person.
- (ii) Where the injury is not specified the Company will pay such Compensation as in its opinion is not inconsistent with the provisions of this schedule.
- (iii) Permanent total loss of use of member shall be treated as loss of member.



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PERSONAL ACCIDENT CLAIM FORM

CLAIM NO: POLICY NO:

STATEMENT BY THE CLAIMANT

1. Name: Present Age:
- Address:
- Occupation:
- Name and Address of Employer:

2.	When and where did the accident take Place?	Date:
		Hour: O'clock in the
		Place:
3.	How did the accident happen and what were you doing at the time? It is necessary that full particulars be given	
4.	Name of injuries sustained have you previously sustained injuries to the same part or parts?	
5.	Are you claiming or entitled to claim Compensation for this accident from any other Company or Society? If so, give particulars.	
6.	(a) Have you been confined to bed or house by the accident? If so, state for how long.	To bed from To.....inclusive To house fromTo.....inclusive
	(b) Are you still confined to bed or house by order of your Medical Attendant.	(b)

<p>7. Have you been for any time since the the accident TOTALLY incapacitated from attending to your usual business or occupation? If so, give the dates and state if you are still totally incapacitated.</p>	<p>From -----To -----inclusive</p>
<p>8. If you have been able to attend to a portion of your business or occupation state when you commenced to do so.</p>	
<p>9. If you are now able to follow your usual Business or occupation give date of commencement.</p>	
<p>10. Name and address of the doctor who is treating you.</p>	

I do hereby declare that the foregoing statements are true, and I agree that if I have made any Untrue statement, the Policy shall be void and my right to compensation shall be forfeited.

Date: ----- 20---- Signature: -----

If this Declaration is made on behalf of the Claimant, please state full Name, Occupation and Address of Declarant.



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FIRE CLAIM FORM

All questions must be answered fully - dashes or ticks are not acceptable

1. NAME OF INSURED:	
2. ADDRESS : Tel. No.:	
3. POLICY NO:	
4. STATE:	
(A) Address of premises where damage occurred	(A)

(B) State as fully as possible how the loss occurred	(B)

(C) Date and Time of damage	(C)
(D) Were the premises unoccupied if so for how long?	(D).....
(E) In case of impact name and address of Third Party	(E)

5. (A) Are you the sole owner of the property?	(A)
(B) If not give name of other interested parties	(B)
6. Are there any other insurances in force in respect of the property mentioned on this form?
7. Particulars of any previous claims for fire explosion riot storm impact.

(The reverse side of this form must also be completed)
I/We hereby declare that the above details are in all respect true.

.....

Date

.....

Signature



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BURGLARY CLAIM FORM

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All questions must be answered fully – ticks and dashes are not acceptable.

Name of Insured

Full AddressTelephone No.

Policy No.

Full address of the premises from which
The loss occurred.

1. When is the theft believed to have
been committed?

2. (a) When was the loss discovered?
(b) By whom was it discovered?

(a)
(b)

3. what is the amount of loss? (Complete
reverse side of this form)

K

4. Describe fully how the thieves entered the
premises and state which doors or windows
were forced

5. From which part of the premises was the property
stolen?

6. (a) Are you the sole occupier of the premises?
(b) If not, give the names of the other occupants.

(a) Yes / No
(b)

STATEMENT OF CLAIM

The amount to be claimed on any article must be limited to the actual intrinsic value at the time of the loss. Details of damage if any should be stated and an estimate for the repairs should be forwarded with this statement.

Item No.	Give full description Of Property	Name and Address of Shop Where bought Or of Person From whom obtained	Date of Purchase Or of Gift	Cost Price	Deduction for wear and tear	Amount now Claimed	Remarks

<p>7. (a) Were the premises occupied at the time of loss? (b) If not, where were they last occupied</p>	<p>(a) Yes / No (b) Date..... Hr.....a.m. / p.m.</p>
<p>8. (a) Has the loss been reported to Police Station (b) If yes, (i) Name of the Police Station (ii) When was the report made? (iii) Name the person who reported to the police (iv) Has any arrest been made? (v) Have any of the stolen items been recovered?</p>	<p>(a) Yes / No (b) (i) (ii) (iii) (iv) Yes / No (v) Yes / No</p>
<p>9. (a) Do you suspect any person of having been implicated in the theft? (b) If Yes, (i) Give name and address of the person (ii) Give reasons why you suspect the person</p>	<p>(a) (b) (i) (ii)</p>
<p>10. (a) Are you the sole owner of the property stolen and/or damaged? (b) If not, give full information regarding ownership</p>	<p>(a) Yes / No (b)</p>
<p>11. What was the total value within the premises at the time of the loss of: (a) all property owned by you (b) goods held by you in trust and on commission</p>	<p>(a) K (b) K</p>
<p>12. (a) Are the premises and/or contents insured against fire? (b) If Yes, (i) Give name of Insurance Company (ii) Give amount insured</p>	<p>(a) Yes / No (b) (i) (ii)</p>

13. (a) Is there any other Insurance covering this loss?

(a) Yes / No

(b) If Yes,

- (i) Give name of Insurance Company
- (ii) Give amount Insurance

(b) (i)
(ii)

14. (a) Have you previously ever suffered loss by fire? Housebreaking or theft?

(a) Yes / No

(b) If Yes, give the following details

(b) **Cause** **Date** **Amount**

- (i) Fire
- (ii) House-breaking
- (iii) Theft

Declaration

I / We hereby declare that the above details are in all respects true and correct.

SIGNATURE OF CLAIMANT:**DATE:**



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CONTRACTORS' ALL RISKS INSURANCE

Notification of Loss or Damage for Contractors' All Risks Insurance

The issue of this form is not to be taken as an admission of liability by the Insurer.

<p>Policy No.</p> <p>Title of contract insured:</p> <p>Name(s) and address(es) of Insured(s):</p> <p>Location and address of Contract Site:</p> <p>Name of supervising Engineer:</p> <p>Nearest railway station (airport):</p> <p>Advisable approach route of Contract Site From railway station (airport) or otherwise:</p>	<p>-----</p> <p>-----</p> <p>-----</p> <p>-----</p> <p>-----</p> <p>-----</p>
<p>1. Which items were damaged?</p> <p>(a) Contract works</p> <p>(b) Construction plant</p> <p>(c) Construction machinery</p>	<p>-----</p> <p>-----</p> <p>-----</p>
<p>2. When did the loss or damage occur? (state date and exact time)</p>	<p>-----</p> <p>-----</p>
<p>3. How did the damage occur and what was its probable cause? (Attach sketch, photos, etc.)</p> <p>4. How far had the constructions of the</p>	<p>-----</p> <p>-----</p> <p>-----</p>

damaged item(s) progressed at the
time of the occurrence of the damage?

5. Give name and address of witnesses
to the occurrence.
.....

6. How will the damaged items be repaired?

7. Will any alterations or improvements be
made to design, construction or material
when repairs are carried out?

8. What are the estimated costs for the
repair of damage to:

(a) Contract works?

(b) Construction plant and equipment?

(c) Construction machinery?

9. Is Third Party Liability involved?

10. Are existing buildings or surrounding
property damaged?

11. Remarks:

The undersigned Insured declares to have answered the above questions
conscientiously and truthfully.

Dated atthisday of200

Signature
