



NICO General Insurance Company Limited

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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. (b) Are you still confined to bed or house by order of your Medical Attendant.	To bed from ----- To-----inclusive To house from -----To-----inclusive (b) -----
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.	From -----To -----inclusive

8. If you have been able to attend to a portion of your business or occupation state when you commenced to do so.	
9. If you are now able to follow your usual Business or occupation give date of commencement.	
10. Name and address of the doctor who is treating you.	

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: _____