NICO General Insurance Company Limited

NICO HOUSE, P.O Box 2592, Blantyre; Tel: 01 822699; Fax: 01 822363; E-mail: nicogen@nicogeneral.com
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'ALL RISKS' CLAIM FORM

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.: ____________

E-mail Address : ____

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 LOST, STOLEN OR DAMAGED ARTICLES MUST BE FURNISHED INCLUSIVE OF ITEM DESCRIPTION, INSURED VALUE, COST OF DEPRECIATION IF POSSIBLE.

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

DATE:-- --

SIGNATURE OF INSURED

NICO GENERAL INSURANCE COMPANY LIMITED

P.O. BOX 2592, BLANTYRE, MALAWI
Tel: (265) 622 699 Telex: 44241 Fax: (265) 622 363 Cables: 'NICOBT'
E Mail: nicomalawi@malawi.net

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	(a)
(b) Name of animal	(b)
(c) Breed	(c)
(d) Colour and distinguishing marks or brands	(d)
(e) Age	(e)
(f) Value prior to illness	(f)
5. Information as to attention given to the animal:	
(a) When was animal first seen ill?	(a)
(b) When was notice of this first sent to the veterinary surgeon?	(b)
(c) When did the veterinary surgeon first see the animal?	(c)
(d) Give dates of subsequent attendance of veterinary surgeon	(d)
(e) When last seen by him	(e)
6. Date of death	Hour Place (address)

7. Cause of death: (a) If from accident, give full details And who was in charge. (b) If from disease, give your opinion as to the cause. (c) If from operation, give details	(a) (b) (c)
8. Purpose for which used or employed. When last at work.	
9. If bought state: (a) From whom (b) Date of purchase (c) Price paid	(a) (b) (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 (2) Actual date of foaling or calving	(1) (2)
13. How many: (a) Mares-in-foal or cows-in-calf have you had this season? (b) Have you had insured this season (c) Have you lost this season	(a) (b) (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: --

1. (a) Are you the usual medical attendant of the claimant? (b) What was the date of your first attendance for the present injuries? (c) Are you still in attendance?	(a) (b) (c)
2. State the cause of the accident as known by you	
3. Give details of the treatment claimant has undergone or is undergoing.	
4. Give particulars of the injuries sustained: (a) Regions injured (b) Nature and extent of the injuries (c) Are the symptoms due to the accident alone or are they traceable to any other cause.	(a) (b) (c)
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.	

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

Use the reverse of this form if further space is required

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

Name: --

Address: ---Date: --

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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.

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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

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. …………..…………………

………………………………………………………..

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

Question	Answer
7. (a) Were the premises occupied at the time of loss? (b) If not, where were they last occupied	(a) Yes / No (b) Date…….. Hr…..….a.m. / p.m.
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?	(a) Yes / No (b) (i) (ii) (iii) (iv) Yes / No (v) Yes / No
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	(a) (b) (i) (ii)
10. (a) Are you the sole owner of the property stolen and/or damaged? (b) If not, give full information regarding ownership	(a) Yes / No (b)
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	(a) K (b) K
12. (a) Are the premises and/or contents insured against fire? (b) If Yes, (i) Give name of Insurance Company (ii) Give amount insured	(a) Yes / No (b) (i) (ii)

13. (a) Is there any other Insurance covering this loss? (b) If Yes, (i) Give name of Insurance Company (ii) Give amount Insurance	(a) Yes / No (b) (i) (ii)
14. (a) Have you previously ever suffered loss by fire? Housebreaking or theft? (b) If Yes, give the following details	(a) Yes / No (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: …………..………