



PAN AFRICA LIFE

PERSONAL ACCIDENT CLAIM FORM

POLICY NO.

TO BE COMPLETED BY THE INSURED AND HIS/HER DOCTOR.

- 1 Name in full:
- 2 (a) Age next birthday;
- 2 (b) Present profession or occupation:
- 3 Present address:
- 4 (a) When and where did the accident occur?
- (b) How did it happen?
(Full description to be given).
- (c) Name and address of any witness of the accident.
- (d) Name and address of the Doctor who attended you immediately after the accident.
- (e) Name and address of the Doctor now attending you.
- (f) Off duties from _____ To: _____
- 5 (a) Did the incapacity commence from the date of the accident?
- (b) If not, when did it commence?
- 6 Are you entitled to compensation from any other company or club in respect of the injury for which you are claiming?
If so, give full particulars.
- 7 When can a medical doctor or other officer of the company visit you if necessary?

Medical Report. Any claim must be supported by a report on the reverse side of this form from the Insured's Medical Attendant, any fee for the report being payable by the Insured.

DECLARATION

I, the undersigned, hereby declare that I am the person referred to in the above statements, which are true .
in every respect and made without reservation and I hereby claim to be paid.

Date:

Signature:

P.T.O

