The Jubilee Insurance Company of Kenya Limited

Claim No:

Policy No:

Personal Accident Claim Form

(If unable to reply personally, this form may be filled on behalf of the claimant)

Head Office:
Jubilee Insurance House, Wabera Street, P.O. Box 30376 - 00100 GPO, Nairobi, Kenya
Tel: 328 1000 Fax: 328 1150 Email: jic@jubileekenya.com

Mombasa Offices:
Jubilee Insurance Building, Moi Avenue, P.O. Box 90220 - 80100, Mombasa, Kenya
Tel: 222 4286 / 231 4019 / 231 6760 Fax: 23 6796 Email: mombasa@jubileekenya.com

Kisumu Offices:
Jubilee Insurance House, Oginga Odinga Road, P.O. Box 378 - 40100, Kisumu, Kenya
Tel: 202 0836 / 202 0532 Fax: 202 0845 Email: kisumu@jubileekenya.com

"To avoid delay and unnecessary correspondence in the processing of your claim please observe the following requirements:-
1. Ensure that both the claim form and the medical certificates are properly completed:
2. Supporting documents or copies thereof plus original medical bills incurred, if any, must be submitted with the claim form."

Claimant' name (in full)

Address

Email Address

Present Occupation Present Age

Policy No. Date of payment of last premium

1. (a) Date of Accident? Time AM ☐ PM ☐

   (b) Where did it occur?

   (c) Describe fully how it happened?

   (d) Give name, occupation and address of a witness of the Accident

   Name

   Occupation

   Address

2. (a) Describe the nature and extent of the injuries you have received.

   (b) Give name and address of the Doctors who have attended you for these injuries

3. (a) State the number of days you have been ENTIRELY confined to your Bed, Room or House

   To Bed for days from to

   To Room for days from to

   To house for days from to

   (b) If you are still confined to your Bedroom or House, state which?

4. (a) State the extent and duration of your inability to attend to your business or occupation
   I have been disabled

   PARTIALLY for days from to

   WHOLLY for days from to

   I am now disabled ☐ Wholly ☐ Partially ☐ Not at all

   (b) If still disabled state how much longer the disability is likely to continue

5. Have you since the accident personally directed or supervised or given any attention whatever to any part of your business or occupation?

If so give full particulars and dates

6. (a) Are you entitled to receive compensation from any other company or other source?

If so, give full particulars

(b) Have you ever claimed compensation from any company

If so, give full particulars

7. Are you perfectly free from any physical Defect, Infirmity or Disease?

DECLARATION

I, the undersigned, hereby declare that I am the person referred to in the above statement, which is true in every respect, and made without reservation.

I hereby authorise the company to apply to my Medical Attendant mentioned above, for a report to be furnished at my expense in the form used by the Company for the purpose.

Date_____ Signed_____

NOTE: The Medical Certificate must be completed by your Doctor before this Claim Form is forwarded to the Company

MEDICAL CERTIFICATE

In order to establish his Claim, the Claimant must obtain and forward to the Company a certificate from a duly qualified and registered Medical Practitioner, and it is essential that this form be filled up as minutely as possible so that the medical officer of the Company may properly understand the nature of the case

The Medical attendant of the claimant is requested to state:-

1. The Name and Occupation of the Claimant

2. The Exact nature and extent of the injuries caused by the accident. If a Hand or an arm. a foot or a Leg. State whether it is the RIGHT or LEFT.

Regions Injured	Nature and extent of

3. Whether the Claimant has suffered or is now suffering from any constitutional or local disease or Physical infirmity. If so state the nature of such disease or infirmity and to what extent it affects the disablement.

4. (a) When and where did you first attend to the Claimant?

Place _____ Time _____ AM ☐ PM ☐

Date _____ Month _____ Year _____

(b) Are you still attending to him? _____

5. To what extent the above accident injuries have necessarily disabled the claimant from giving attention to business.

Claimant has been disabled

TOTALLY for _____ days / PARTIALLY for _____ days

Claimant is now ☐ Totally disabled ☐ Partially disabled ☐ Not at all disabled

The further disability (If any) will in my opinion continue

for _____ entirely / for _____ partially from the present time

Total Disablement arises when the claimant is rendered completely incapable of attending to any part of his ordinary profession, business or occupation. Partial Disablement arises when the claimant is a little injured, or has so far recovered from injuries as to be capable of attending to some portion of his ordinary profession, business or occupation.

6. (a) If the claimant is now, in any way, attending to business, on what day he first commenced doing so after the accident

(b) If not whether you consider Claimant fit to personally supervise or direct his Business or Occupation.

7. Have you any reason to think that the patient was not perfectly sober at the time of the accident?

8. Is there any information, professional or other wise that you consider should be known to the company.

REMARKS: If any:

I certify that I have satisfied myself by personal examination that the Claimant has sustained an accident causing injuries as above described

Signature and Stamp _____ Qualifications _____

Date _____ Address _____