

OCCIDENTAL INSURANCE COMPANY LIMITED

Crescent Business Centre, 7th Floor, Parklands Road, Parklands, P.O. Box 39459-00623, Nairobi, Kenya.

Policy No._____

| Claim | No. | |
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PERSONAL ACCIDENT CLAIM FORM

| 1. (a)Name of Insured(in full) (b)Address(in full) (c)Profession or occupation 2. (a)No. of Policy (c)Profession or occupation 3. (a)Date and time when accident occurred 20 20 21 (b)Where it happened (c)Name and address of witness 4. How did the accident occur 5. Nature of injury received (iff to limb or eye, state whether right or left) 6. (a)Nature of disablement (b)Extent of disablement (c)Insure and address of surgeon or Doctor in attendance 8. (a)Where and when can a medical officer of the company visit you if necessary? (b)Name of the nearest railway station and distance there from 9. (a)Are you insure in any other office(s) granting compensation for occident? (b)State name and address of company or companies and amount of insurance 10. If you are claiming for temporary disablement, does your weekly income immediately before the accident exceede by 50% the total weekly compensation you will receive now from this and all other sources? I hereby declare that the foregoing statements are made by myself and are true in all respects and that I have not abstrained from my usualoccupation longer than is absolutely necessary; and I agree that if I have not abstrained from my usualoccupation longer than is absolutely necessary and I agree that if I have not abstrained from my usualoccupation longer than is absolutely necessary; and I agree that if I have made , or, in any further declaration the company anything with which it ought to be made acquainted, and also that I have not abstrained from my usualoccupation longer than is absolutely necessary; and I agree that if I have made , or, in any further declaration the company may frequire shall make any false or fraudient statement or any supression, concealment or untrue averement whatever, the policy shall be void, and my right of compensation absolutely forfeited; and I am willing, if required, to make a statutory declaration before a justice of the peace and reconcilation of the truth of the whole of the foregoing statement or any other statemat I make in conn | TO BE COMPLETED BY THE INS | URED Important notice | :The Issue of this form is not to be to | aken as an admission of liability. |
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| (c)Name and address of witness 4. How did the accident occur 5. Nature of injury received (if to limb or eye, state whether right or left) 6. (a)Nature of disablement (b)Extent of disablement (c)Present state of incapacity 7. Name and address of Surgeon or Doctor in attendance 8. (a)Where and when can a medical officer of the company visit you if necessary? (b)Name of the nearest railway station and distance there from 9. (a)Are you insure in any other office(s) granting compensation for accident? (b)If so state name and address of company or companies and amount of insurance 10. If you are claiming for temporary disablement, does your weekly income immediately before the accident exceede by 50% the total weekly compensation you will receive now from this and all other sources? I hereby declare that the foregoing statements are made by myself and are true in all respects and that I have not attempted toconceal from the company anything with which it ought to be made acquainted, and also that I have not abstained from my usualoccupation longer than is absolutely necessary; and I agree that if I have made , or, in any further declaration the company may require shall make any false or fraudlent statement or any supression, concealment or untrue averment whatever, the policy shall be void, and my right compensation absolutely forfeited; and I am willing, if required, to make a statutory declaration before a justice of the peace and reconciliation of the truth of the whole of the foregoing statement or any other statemnt I make in connection with this claim Witness: Signature of Claimant: Date: CERTIFICATE TO BE FILLED UP AND SIGNED BY AN EYE WITNESS OF THE ACCIDENT I hereby certify that I was present when the accident ocurred to Mr/Mrs. on the day of 20 in the manner stated by him overleaf, that it * was caused by / was not caused his willfull act, and that he was not ums=der the influence of intoxicating substance at the time Name Occupation | 1. (a)Name of Insured(in full) (b)Address(in full) | | | |
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| not attempted toconceal from the company anything with which it ought to be made acquainted, and also that I have not abstained from my usualoccupation longer than is absolutely necessary; and I agree that if I have made, or, in any further declaration the company may require shall make any false or fraudlent statement or any supression, concealment or untrue averment whatever, the policy shall be void, and my right of compensation absolutely forfeited; and I am willing, if required, to make a statutory declaration before a justice of the peace and reconciliation of the truth of the whole of the foregoing statement or any other statemnt I make in connection with this claim Witness: | by 50% the total weekly compensation yo | ou will receive now tro | m this and all other sources?_ | |
| CERTIFICATE TO BE FILLED UP AND SIGNED BY AN EYE WITNESS OF THE ACCIDENT I hereby certify that I was present when the accident ocurred to Mr/Mrs on theday of20in the manner stated by him overleaf, that it * was caused by / was not caused his willfull act, and that he was not ums=der the influence of intoxicating substance at the time NameOccupation Address | I have not abstained from my usuald made, or, in any further declaration any supression, concealment or untrue absolutely forfeited; and I am willing, i reconciliation of the truth of the whole | occupation longer the the company may re a averment whatever, if required, to make a | in is absolutely necessary; are equire shall make any false o the policy shall be void, and n statutory declaration before a | nd I agree that if I have or fraudlent statement or only right of compensation justice of the peace and |
| CERTIFICATE TO BE FILLED UP AND SIGNED BY AN EYE WITNESS OF THE ACCIDENT I hereby certify that I was present when the accident ocurred to Mr/Mrs on theday of20in the manner stated by him overleaf, that it * was caused by / was not caused his willfull act, and that he was not ums=der the influence of intoxicating substance at the time NameOccupation Address | Witness: | | Signature of Claimant | |
| CERTIFICATE TO BE FILLED UP AND SIGNED BY AN EYE WITNESS OF THE ACCIDENT I hereby certify that I was present when the accident ocurred to Mr/Mrs on theday ofin the manner stated by him overleaf, that it * was caused by / was not caused his willfull act, and that he was not ums=der the influence of intoxicating substance at the time NameOccupation Address | Address: | | | |
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| on theday of20in the manner stated by him overleaf, that it * was caused by / was not causedhis willfull act, and that he was not ums=der the influence of intoxicating substance at the time NameOccupation Address | CERTIFICATE TO BE FILLE | ED UP AND SIGNED | BY AN EYE WITNESS OF | THE ACCIDENT |
| his willfull act, and that he was not ums=der the influence of intoxicating substance at the time NameOccupation Address | I hereby certify that I was on theday him overleaf, that it * w | present when the y of vas caused by / v | accident ocurred to Mr/ 20in the mar as not caused | Mrs nner stated by |
| Address | | | | |
| Address | Name | | Occupation | |
| | | | | |
| SignatureDate: | | | | |