PERSONAL ACCIDENT CLAIM FORM

AAR INSURANCE KENYA LIMITED
GEORGE WILLIAMSON HOUSE, 4TH NGONG, 2ND FLOOR,
P.O. BOX 41766-00100, TEL: 020 – 2895000/2715319
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MPESA PAYBILL NO. 333200

CLAIM NO: ____________________

POLICY NO: ____________________

Note: If the claimant is too ill to write, this form should be completed by the responsible person in charge of him/her.
No claim can be considered without the properly completed medical certificate overleaf, furnished at the expense of the claimant.

SECTION 1 - INSURED'S DETAILS

1. Name of the insured: ____________________
2. Contact details: Tel: __________ ID No: __________
   Email: __________ Address: __________
   Age: __________ Occupation: __________

SECTION 2 – ACCIDENT DETAILS

1. Date of accident: __________ Time: __________
2. Place where accident took place: ____________________
3. How did the accident occur? ____________________
4. Nature of injury received: ____________________
   (If limb, eye, foot, leg, arm or hand state whether left or right)
5. Nature of disablement: ____________________
6. Extent of disablement: ____________________
7. Confined in house: From: __________ To: __________
8. Partial disablement: From: __________ To: __________
9. Present state of incapacity: ____________________
10. Have you previously suffered injury to the same part, or a similar illness? Yes ☐ No ☐
11. Name and address of surgeon/ Doctor in attendance: ____________________
    ____
12. Where and when can our medical officer of the company visit you when necessary?
    ____
13. Are you insured in any other office/ offices granting compensation for the accident?
    Yes ☐ No ☐
    If so, state the name and address of the company/ companies and the amounts of insurance ____________________
14. Name and Addresses of the witnesses

NAME OF WITNESS	TEL/ ADDRESS

Insured's signature: ____________________ Date: __________

Witness' signature: ____________________ Date: __________

THE INJURY / ILLNESS

1. Details of injury/illness: ____________________
2. Have you previously suffered injury to the same part, or a similar illness? Yes ☐ No ☐
3. Date you were first totally incapacitated: ____________________
4. Date of doctor's first attendance: ____________________
5. Name of doctor first attending Who is your usual doctor: ____________________
6. For what previous injury or illness have you received medical attention? ____________________
7. Please give full details with dates. ____________________
8. What occupations have you followed since the date of proposal for this insurance?
9. Have you been prevented, on your doctor's advice, from engaging in work of any kind? Yes ☐ No ☐
   If YES, give dates and state "continuing" if necessary.
10. Are you now capable of any kind of work? Yes ☐ No ☐
    If YES, what work and from what date? ____________________
11. Are you now capable of full work? Yes ☐ No ☐
    If YES, from what date?
12. Are you entitled to claim compensation for this accident / illness from any other insurer? Yes ☐ No ☐
    If YES, give particulars ____________________

DECLARATION

I declare that the particulars upon this form are true and complete.

Date: ____________________ Signature: ____________________

MEDICAL CERTIFICATE

THIS CERTIFICATE IS TO BE COMPLETED BY A DULY QUALIFIED AND REGISTERED MEDICAL PRACTITIONER AT THE INSURED'S EXPENSE

NB: BY TOTAL DISABLEMENT, IT IS UNDERSTOOD THAT THE CLAIMANT IS PREVENTED BY THE INJURY FROM ATTENDING TO ANY PORTION OF HIS DUTIES

1. Name of Patient? ____________________
2. When were you first consulted? ____________________
3. What injuries has the patient sustained? ____________________

4. When and for what previous injuries and illness have you attended him? ____________

____

5. To what is the injury / illness directly attributable? ____________________

____

6. If accident, have you reason to believe the claimant was not sober or was under the influence of drugs at the time? If "Yes", give details: ____________________

____

7. Is or was the claimant suffering from any other complaint which might have contributed to his present condition or might delay recovery? Yes ☐ No ☐
   If so please give details: ____________________

____

8. For how long has the patient been totally incapable of any kind of work:
   FROM ____________ TO ____________

9. For how long has the patient been partially incapable of any kind of work:
   FROM ____________ TO ____________

10. Do you consider the patient having suffered any permanent disability?
    Yes ☐ No ☐
    if yes, please give details ____________________

____

DECLARATION

Name of Medical Practitioner: ____________________

Address: ____________________

Qualifications: ____________________

Date: ____________________

Signature and Rubber Stamp: ☐