GROUP PERSONAL ACCIDENT CLAIM FORM

AAR INSURANCE KENYA LIMITED
GEORGE WILLIAMSON HOUSE, 4TH NGONG, 2ND FLOOR,
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MPESA PAYBILL NO. 333200

CLAIM REFERENCE 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.
POLICY NO: ____________________

SECTION 1 - EMPLOYER DETAILS

1. NAME OF EMPLOYER
2. CONTACT DETAILS: TEL: __________ WEB: __________
   ID NO: __________ PIN NO: __________
   EMAIL: __________ POSTAL: __________
   CODE: __________ TOWN/ CITY: __________
3. INJURED EMPLOYEE: NAMES: __________
   MOBILE: __________ ID NO: __________
   PIN NO: __________ EMAIL: __________
   POSTAL: __________ CODE: __________ TOWN: __________
4. (A) OCCUPATION: __________ (B) AGE: __________ (C) MARITAL STATUS: __________
   (D) HEIGHT: __________ (E) WEIGHT: __________
5. IF ACCIDENT, PLEASE STATE:
   Date: __________ Time: __________
   Were you perfectly sober? Yes ☐ No ☐
   If No, give details: __________
   ____
   Where did accident occur? __________
   How did it happen and what were you doing at the time? __________

NAME OF WITNESS	TEL/ ADDRESS

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? ____________

   Please give full details with dates. ____________

7. What occupations have you followed since the date of proposal for this insurance?

8. 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.

9. Are you now capable of any kind of work? Yes ☐ No ☐
   If YES, what work and from what date? ____________
10. Are you now capable of full work? Yes ☐ No ☐
    If YES, from what date? ____________
11. 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: ____________

(Rubber Stamp if Corporate)

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: