Alliance Africa General Insurance Limited
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PERSONAL ACCIDENT / GROUP PERSONAL ACCIDENT CLAIM FORM

(The issue of this form is not to be taken as an admission of liability)

1. Insured Information

- **Policy No.:** .....
- **Name:** .....
- **Address:** .....
- **Profession/Occupation:** .....
- **Tel. No.:** .....
- **Age:** .....**Height:** .....**Weight:** .....

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2. Medical Information

- **Doctor's Name & Address:** .....
- **Is this your usual Medical Attendant?** Yes / No
- **Date first consulted:** .....
- **When can you be seen?** .....

Disablement Periods

- Wholly unable to attend occupation: From ___ / ___ / ___ To ___ / ___ / ___
- Partly able to attend occupation: From ___ / ___ / ___ To ___ / ___ / ___

Other Benefits

- Names & addresses of other Insurers/Societies/Clubs: .....
- Amount of benefits: .....

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3. Accident Details

- **Date & Time (a.m./p.m.):** .....
- **Place:** .....
- **Details of Accident (what you were doing at the time):** .....
- **Injuries sustained (specify left/right if applicable):** .....
- **Previous similar injuries?** Yes / No (If yes, give details) .....
- **Witnesses (names & addresses):** .....
- **Date incapacity started:** .....

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4. Notes for Insured

- Any fee for Medical Certificate is payable by the Insured.
- Further Medical Certificates are required at fortnightly intervals during periods of total temporary disablement.
- The Insured may be required to submit to Medical Examination at the expense of the Company.

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5. Declaration

I hereby declare that the above statements are true in every respect and are made without reservation. I claim to be paid the benefit due under the policy.

- **Signature:** .....
- **Date:** .....

MEDICAL CERTIFICATE

(To be completed by the Claimant's Medical Attendant)

1. Claimant's Name in full: .....
2. Nature and extent of injuries (specify left/right if limb): .....

3. Cause of accident (as known to you): .....
4. Date of first attendance: .....
    - Are you still in attendance? Yes / No
5. Are you the usual Medical Attendant? Yes / No
    - If yes, how long have you known the claimant and for what conditions? .....
6. Are symptoms due exclusively to accident? Yes / No
    - Any contributory disease/infirmity? .....
    - Any history of gout, rheumatism, diabetes, fits? .....
    - Any intoxication suspected at time of accident? .....
7. Confinement details:
    - **Temporary Total Disablement:** From ___ To ___
    - **Temporary Partial Disablement:** From ___ To ___
8. Ability to attend occupation:
    - From what date? .....
    - Probable date of complete recovery: .....
9. Permanent disability? Yes / No
    - If yes, degree/percentage: .....
    - If no, date of recovery: .....
10. Further remarks: .....

Certification and Data collection consent

Data Collection Consent: I consent to the collection, verification, processing, storage and lawful use of my personal data for identification, regulatory compliance, and the provision of insurance services

I hereby certify that the above named met with the accident referred to and that the foregoing statements are correct.

- **Signature:** .....
- **Qualification:** .....
- **Address:** .....
- **Date:** .....