



GA INSURANCE LIMITED

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PERSONAL ACCIDENT CLAIM FORM AND MEDICAL CERTIFICATE

This form must be filled up by the claimant and the Medical Certificate on the other side by his Medical Attendant, and return to the Company, within **three days** of receipt.

POLICY NO. í í í í í í í í íCLAIM NO. í

PLEASE USE BLOCK LETTERS	
FULL NAME í ..	
FULL ADDRESS í ..	TELEPHONE : í í í í í í í í í í í í í í
OCCUPATION OR BUSSINESS í ..	PIN NO. í ..

- State number of days necessarily and entirely confined to bed, room or house, as the sole and direct result of the accident.

<u>To Bed</u> For í í í í ..days From í í í í í .. to í í í í í í í (Both inclusive)	<u>To House</u> For í í í í í í ..days From í í í í í í í To í í í í í í í í . (Both inclusive)
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- Have you in any way attended to business or work during the above period?.....
- State the date on which you were first able to attend to the portion of your business, either commercial, superintending or working í í í í í í í í í í í í í í í í
- State number of days partially disabled from attending to business or work.
For í í í í í í í í í days from í í í í í í í í í ..to í í í í í í í í í (Both inclusive)
- State what business or work you have been partially disabled from attending to, and in what way has the accident prevented you from attending.

} í	í í
	í í
	í í

State what amount is claimed in full discharge of all claims for the accident.

Total disablement í í .weeks at í í per week, Kshs. : _____

Partial disablement í í weeks at í ...per week, Kshs. : _____

Kshs.

I do hereby declare that I have not abstained from business or work, either entirely or partially, longer than was absolutely necessary; and I claim the above amount under Policy No. í í í í í í í í .., and agree to accept the same full and complete discharge of all demands upon the corporation in respect of the accident to which the foregoing statement refer.

I DO HEREBY WARRANT the truth of the foregoing statements in every respect, and I agree that if I have made, or in any further declaration the Directors may require of me in respect of the said accident shall make, any false or fraudulent statement, or any suppression, concealment, or untrue averment whatever, the policy shall be void against the Corporation, and my right to compensation, present or future, absolutely forfeited, and I am willing, whatever requirement, to make a solemn declaration before a justice of the Peace of the truth of the foregoing statement, and of such other particulars as may reasonably be required by the directors.

Witness í .Signature of Claimant í í í í í í í í í í í í í í í í í
Address í .Date í ..

CERTIFICATE OF MEDICAL ATTENDANT

In the case of _____ ..

Insured as _____ .

1. First date of attendant of Claimant for the accident _____ .

2. State where soon _____ ..

3. Last date of seeing Claimant _____

4. State where soon _____

5. Is the occupation of Claimant, as above, fully and correct stated?.....

6. The time within your own knowledge, that the claimant has been, as the direct and sole consequence of the injuries sustained, necessarily confirmed to his bed, bedroom or house. To Bed from _____ to _____ (both inclusive) To House from _____ to _____ (both inclusive)

7. On which date was the claimant able to, for the first time, to attend to some business, either commercial, superintending or working?.....

8. The time, within your own knowledge, during which he has partially disabled from attending to business or work from _____ day of _____ .to _____ ..day of _____ . (both inclusive)

9. Has the disablement extended beyond the normal time for similar injuries?.....

10. if so, state to what cause or causes this is due _____ ..

I CERTIFY that I have personally attended and examined the above-named Claimant during the period from the date of the accident till the _____ .inst., at least _____ .times in each week, that he has not abstained from his occupation, as above described, longer than absolutely necessary, and that the foregoing statement are full and correct.

Signature _____ Qualifications _____

Address _____ ..Date _____ ..