MAYFAIR INSURANCE COMPANY ZAMBIA LIMITED
P O BOX 34702, Lubuto House, Rhodes Park, Lusaka, Zambia
Tel: +260 211 255 182/3 Fax: +260 211 255 163
Email: info@mayfairzambia.com

PERSONAL ACCIDENT CLAIM FORM

IMPORTANT Please answer every section

Policy No				
Name of Insured				
Address				
Designation				
Type of work (describe duties in full)				
Basic salary/earnings (per annum) :		Date of accident		
Place of Accident		Time		
1 How did the accident occur?				
2 What were you doing?				
3 ZWas it fatal?	Yes		No	If not fatal, what are the apparent injuries?
Head				
Arm				
Legs				
Trunk				
Hips				
Hand				
Ribs				
Have the above part(s) been injured previously		Yes	No	
5 How long have you been totally Disabled/partially disabled?				

6 Have you now resumed you employment/ Duties? When?	Yes	No	

7 How long have you been bed Ridden?	
8 How long have you been confined to your house?	

9 To which hospital were you admitted?					
10 Were you operated on?	Yes		No		
11 Name and address of doctor who operated on you:					
12 Is he your usual doctor?	Yes		No		
13 Name and address of doctor treating you:					
Have you undergone medical or surgical treatment during the past five years?	Yes		No		
If yes, give particulars:					
14 Name and address of any witnesses					
15 Are you insured for personal accident with any other company?	Yes		No		
If yes, give name/address of branch					
16 Do you hold a life policy?					
If yes, give name and address of insuring company					

I hereby declare that the aforegoing statements are true and within my knowledge and belief

Dated at _____ This _____ Day of _____ 19 _____

Insured signature _____

NB Our claims service can be good only if you promptly complete and submit the claim form as well as the required documentation listed.

Always quote the claim number in any communication. This number will be advised to you immediately on receipt of the claim form.

MEDICAL CERTIFICATE

(To be completed by a qualified medical practitioner)

1 Name of the patient	
2 What injuries has the patient sustained?	
3 X-ray results:	
4 When were you first consulted?	

5 Has the patient any permanent disablement	Yes		No	
Permanent disablement	%	Partial disablement		

6 How long has the patient been totally disabled

Totally : From		To	
Partially : From		To	

7 Has the patient any disease or physical defect and if so, of what nature?

8 If (7) above is affirmative, has this aggravated in any way the present injury and if so what Is the percentage of aggravation?

9 On the basis of the continental permanent disability scale showing below, do you consider That the patient has suffered any

Permanent disability? |

If so, what is the percentage? |

SCALE OF DISABLEMENT UNDER EVENT OF THE POLICY

1 Permanent Disablement

Loss of two limbs or sight of two eyes or one limb eye		
Loss of one limb one eye		
Total and irreversible paralysis		

2 Permanent Partial disablement

Loss of four fingers		
Loss of thumb	- Both phalanges	
	- One phalanx	
Loss of index finger three Phalanges		
	- two phalanges	
	- one phalanx	
Loss of other fingers	- three phalanges	
	- two phalanges	
	- one phalanx	
Loss of all toes		
Loss of great toe	- one phalanx	
	- two phalanges	
Loss of other tow		
Total and permanent loss of hearing		
	- both ears	
	- one ear	

When the injury is not specified, the Company will adopt percentage of disablement which in its opinion is not inconsistent with the positions of this compensation scale.

Name of medical practitioner			
Address		Telephone	
Date		Signature	