GEMINIA INSURANCE COMPANY LIMITED

6TH FLOOR GEMINIA INSURANCE PLAZA KILIMANJARO AVENUE
P.O. BOX 61316 CITY SQUARE NAIROBI 00200 KENYA
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Personal Accident Claim Form

This printed form is forwarded on receipt of notice of an Accident and its issue to the Policy-holder is in no way an admission of liability. The form must be completed and returned to the Company at the above address. Within ten days of it being sent to the Policy-holder's last known address. The Medical report must be returned as soon as possible by the Medical Practitioner direct to the Company at the abov address.

The Policy-holder and the Insurance

1. Name (in full) ..... Profession, Business or Occupation.....
(If more than one, state all).

Insured Person's Age ..... Years. Height..... feet ..... inches Weight..... lbs

Residential Address..... Business Address .....

Name, Address and Business of Employer.....

.....

2. Policy Number ..... Renewal Date ..... Date last Premium Paid .....

To whom was Premium Paid ..... Whether Paid by Cash or Cheque .....

The Accident

3. (a) When did it occur? on the ..... day of .....20..... at ..... o'clock in the .....

(b) Where did it occur? .....

(c) State how the Accident was caused, and what you were doing at the time .....

.....

(d) 1. If accident injury arose out of the use of a motor vehicle, for what purpose was it being used? } Business.....
Pleasure .....

2. Name and address of Motor Insures? .....

(c) State as preisely as you can what injuries you have sustained .....

.....

(if to an eye, hand or arm, foot or leg, please state whether it is the Right or Left)

4. Name and Address of the Doctor who attended you for injuries described

Name .....

Address .....

Date disablement commenced .....

Describe the extent and Duration of your disability	**Totally Disabled**	**Partially Disabled**	**Present state of Disability**
	for ..... days	for ..... days	.....

Note: By Totally Disabled it is understood that the Claimant is prevented by the injury from attending to any business or occupation. Partially Disabled is when the Claimant is so slightly injured, or has so far recovered, as to be able to transact some portion of business or occupation, but not the whole.

To what extent have you been able since the accident to attend to business or engage in any occupation? .....

Are you, or have you ever been insured against Personal Accident with any other Insurance Company? .....

Have you ever made a claim or received any payment from this Company or any Insurance Company? .....

If so, state number of claims ..... Total amount of Compensation £ ..... Year or Years of claim(s) .....

I Hereby Warrant The Truth of the foregoing statement in every respect, and I agree that if I have made any false or fraudulent statement, or any supression, concealment, or untrue averment, the Policy shall be void, and my right to compensation absolutely forfeited

Date.....20..... Signature .....