Personal Accident Claim Form



LIFE INVESTMENTS HEALTH INSURANCE PROPERTIES ADVICE

Liberty General Insurance Uganda Limited 3rd Floor, 99 Buganda Road P.O. Box 22938 Kampala, Uganda t + 256 (0) 31 2246500

IMPORTANT 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.

EAUL Claim No.

Policy number Full name of claimant Telephone number Address Occupation Date of accident Were you perfectly sober? Where did accident occur? How did it happen and what were you doing at the		Dees		M	M							Age				Hei	ght						Weig	ht				_
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Address																												
Name of witness																												
Address																												
DETAILS OF INJURY/ILLNESS																												
Have you previously suffered injury to the same		es		N	lo																							
part, or a similar illness Date you were first totally incapacitated	D	D]] _	М	М]] _	Υ	Y	Υ	Υ			Date c	of doct	or's fire	t atte	ndan	Ce.	D	D	1 _	М	M	1 _	Υ	Y	Υ	Υ
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Name of doctor first attending																<u> </u>	+	<u> </u>					<u></u>					_
Who is your usual doctor? For what previous injury or illness have you																+	<u> </u>	<u></u>			<u></u>	<u></u>	\vdash	<u></u>	<u></u>		=	
received medical attention																								<u></u>		Щ		
																					_	_	_					
16/2017																												

Please give full details with dates																											
	D	D -	М	М	- \	/ \	/ Y	Y											D	D	- [М	М	-	Υ	YYY	· Y
What occupations have you followed since the date of proposal for this insurance?																											
Have you been prevented, on your doctor's advious of any kind?	ce, from	engagi	ng in w	ork		Yes		No																			
If YES, give dates	From	D	D	- 1	M N	1 -	Y	Υ	Υ	Υ	То	D	D	-	М	М	-	Υ	Υ	Υ	Υ	(state	e "cor	ntinuir	ng" if r	ecessa	ary).
Are you now capable of any kind of work?				Yes			No																				
If YES, what work and from what date																			D	D	- [М	М	-	Υ	ΥΥ	Y
Are you now capable of full work?				Yes			No																				
If YES, from what date	D	D -	М	М	- \	′ \	/ Y	Υ																			
Are you entitled to claim compensation for this a	ccident,	/illness	from ar	ny othe	r insul	er?																		Yes	5		No
If YES, give particulars																											
I declare that these particulars are true and c	orrect.																										
Signature of Insured																	D	ate	D	D	-	М	М	-	Υ	YY	Y

Medical Certificate



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THIS CERTIFICATE TO BE COMPLETED BY A DULY QUALIFIED AND REGISTRED MEDICAL PRACTITIONER AT THE INSUREDS EXPENSE

NB: BY TOTAL DISABLEMENT, IT IS UNDERSTOOD THAT THE CLAIMANT IS PREVENTED BY THE INJURY FROM ATTENDING TO ANY PORTION OF HIS DUTIES

														E	EAUL	. Clair	n No.													
PATIENT DETAILS																														
Full name																														
When were you first consulted?	D	D	-	М	М	-	Υ	Υ	Y	Y																				_
What injuries has the Patient Suffered																														
Date of your first attendance	D	D	-	М	М] -	Υ	Υ	Υ	Υ											Are yo	ou stil	l in at	tenda	ance	Υ	'es		N	lo
To what is the injury/illness directly attributable																														
																														_
																														-
If an accident, have you reason to believe the Pat	ient v	vas no	ot sob	oer or	was	unde	r the	influe	nce c	of dru	gs at	the tii	me o	f the a	accid	ent?										Y	es es] [N	lo
Is or was the Patient suffering from any other cor																	covery	/?								Y	'es		N	lo
If YES please give details																												J		
																														_
	-16			c	La			F				7			1					1			1							
For how long has the patient been totally incapal								From		D	D] -	M	M] -	Y	Y	Y	Y	To	D	D] -] _	M	M] -] _	Y	Y	Y	Y
For how long has the patient been partially incap On the Scale below, do you consider that the Pat						aanor	nt dica		ı	D	es D		M	M No] -	Y		Y If so	Y	To	D	D D		M tage a			Y	Y	Y	Y %
Name of Medical Practitioner	lentn	as sui	lerec	ariy	реп	lailei	IL UISa	Dilley			E3			\U				11 50	Pieas	e ii idi	Late	.iie pe	T	lage	Johne	.abie				/0
Qualifications										<u> </u>				<u> </u>					<u> </u>											
Physical address														<u> </u>					<u> </u>											
Thysical dddress																														
Postal address																			<u> </u>				<u> </u>		l I					
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Signature of Insured																			1	Date	D	D] -	М	M] -	Υ	Υ	Υ	Υ
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Rubber stamp																														

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ERMANENT DISABILITY SHALL MEAN	PERC	ENTAGE OF COMI	PENSATION
loss by physical separation at or above the wrist ankle of one or more limbs		100	
permanent and total loss of whole eye or loss of sight_			100
sight of eye except perception of light			75
permanent and total loss of hearing both ears		100	
one ear	25		
f) permanent and total loss of speech		100	
injuries resulting in permanent total incapacity from following usual occupation or any other occupation for which such person is fitted by knowledge or training		100	
) loss of four fingers		70	
g) Loss of thumb - both phalanges			25
loss of one phalanx		10	
n) loss of index index finger		10	
two phalanges		8	
one phalanx	4		
loss of middle finger -Three phalanges		6	
two phalanges		4	
one phalanx	2		
loss of ring finger - three phalanges		5	
two phalanges		4	
one phalanx	2		
c) loss of little finger -three phalanges		4	
two phalanges		3	
one phalanx	2		
loss of metacarpals -first or second (additional)			3
third, fourth or fifth 9additional)		2	
n) loss of toes - all on one foot		30	
great, both phalanges		5	
great, one phalanx		2	
other than great, if more than one toe lost, each		2	
(i) Where the injury is not specified, the company will pay such sum as, in their opinion, is consistent with the above provisions.			
(ii) Permanent total loss of use of part of the body shall be treated as loss of such part.			

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