



associated with Sanlam group

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PERSONAL ACCIDENT CLAIM FORM

CLAIM NO: _____ POLICY NO: _____

STATEMENT BY THE CLAIMANT

1. Name: _____ Present Age: _____
Address: _____
Occupation: _____
Name and Address of Employer: _____

2. When and where did the accident take Place?	Date: _____ Hour: _____ O'clock in the _____ Place: _____
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3. How did the accident happen and what were you doing at the time? It is necessary that full particulars be given	
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4. Name of injuries sustained have you previously sustained injuries to the same part or parts?	
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5. Are you claiming or entitled to claim Compensation for this accident from any other Company or Society? If so, give particulars.	
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6. (a) Have you been confined to bed or house by the accident? If so, state for how long. (b) Are you still confined to bed or house by order of your Medical Attendant.	To bed from _____ To _____ inclusive To house from _____ To _____ inclusive (b) _____
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7. Have you been for any time since the the accident TOTALLY incapacitated from attending to your usual business or occupation? If so, give the dates and state if you are still totally incapacitated.	From _____ To _____ inclusive
8. If you have been able to attend to a portion of your business or occupation state when you commenced to do so.	
9. If you are now able to follow your usual Business or occupation give date of commencement.	
10. Name and address of the doctor who is treating you.	

I do hereby declare that the foregoing statements are true, and I agree that if I have made any Untrue statement, the Policy shall be void and my right to compensation shall be forfeited.

Date: _____ 20_____ Signature: _____

If this Declaration is made on behalf of the Claimant, please state full Name, Occupation and Address of Declarant.