FBC Insurance

Injury Claim Form

Head Office
6th Floor FBC Centre, 45 Nelson Mandela Avenue, P.O. Box 1227
Harare, Zimbabwe
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All Questions Must Be Answered

Statement To Be Furnished By (Or On Behalf Of) Injured Person **Claim No**

Name of Insured in full

Address

Height Weight Age Occupation (describe fully)

2.How did the accident occur?(please state fully)

3. When and where did the accident occur? (a) Date (b) Time

(c) Place

4. Who witnessed the occurrence?

5. Nature of injuries

6. Have you been totally and completely disabled as a result of the injuries received? Yes No

7.When did (a) total disablement commence?

(b) Confinement to the house commence?

8. Are you at the present time (a) totally disabled? Yes No

(b) Confined to the house?

9. When do you anticipate being able (a) to leave the house

(b) Resume at least part of your duties or attend to some portion of your business?

10.Give name and address of the Doctor who attended to you immediately after the accident

11.(a) Who is your usual Medical Attendant?

(b) Have you consulted him in respect of your present injuries? Yes No

(c) When did you last consult him prior to this accident and for what purpose?

12.Are you claiming under any other Policy or Policies in respect of this Accident? Yes No

If so, state name of Company or Companies

13.State Policy No

Dated the day of (month) 20

Signature

Address

Please Have Medical Certificate Printed Overleaf Completed Medical Certificate
(To Be Furnnished At The Expense Of The Injured Person)

Regarding the Injuries sustained by

1. Are you the Insured's usual Medical Attendant? Yes No

2. (a) When did you first see the Insured in respect of this Accident?

(b) Where did you then see him/her?

3. Nature and extent of injuries

4. Do the injuries seem consistent with the description of the accident given in answer to Question No.2 by the insured? Yes No

5. Is the Patient now, or was he/she at the time of accident suffering from or affected by any physical infirmity, disease or illness, irrespective of the injuries Yes No

or is he/she suffering from or has he/she suffered from any cardiac affection, out, rheumatism, or fits of any kind? If so give particulars Yes No

6. When did you last see the Insured?

(b) Where did you then see him/her?

(c) Will you be seeing him/her again in respect of his/her present injuries? Yes No

7. Have you previously attended the Insured? Yes No

If so, state for what purpose, with date or dates

8. Are you aware of anything in the previous medical history of the Insured which might have contributed to the accident or which is in any way likely to retard his/her recovery from it? Yes No

(Please see that only the Section (a) (b) (c) or (d) applicable to the case is completed)

9. (a) The Insured was totally disabled from the to the but was able to resume part of his/her duties on that date, and should be able to resume all his/her duties within the next weeks, or

(b) The Insured was and is still totally disabled, but should be able to resume part of his/her duties in about weeks' time and partial disablement, should then cease in about weeks, or

(c) The Insured has not been totally disabled, but has not been able to attend to all his/her duties. He/She should, however, be able to do so within the next weeks, or

(d) The Insured has not been totally disabled, but was partially disabled from the to the

I certify that I have examined the abovementioned person, and I have read the answers given by him/her to the questions on the previous page which appear to be in accordance with the present appearance of the injuries, and that there are no further circumstance's except tending to produce total or partial disablement.

Dated the day of (month) 20

Signature Qualifications

Address